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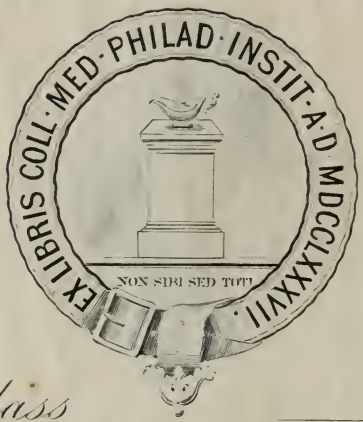

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TRANSACTIONS

OF THE

Homœopathic Medical Society

OF THE

STATE OF PENNSYLVANIA.

Twenty-Second Annual Session,

1886.

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To the Homœopathic Medical Society of Pennsylvania:

The Proceedings and Papers of the Twenty-second Annual Session are hereby respectfully submitted:

CLARENCE BARTLETT, M.D.,
J. F. COOPER, M.D.,
HORACE F. IVINS, M.D.,

Publishing Committee.

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**Deceased.*

DR. DAVID COWLEY,

President of the Homœopathic Medical Society

OF THE

State of Pennsylvania.

DIED, OCTOBER 30th, 1886.

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PROCEEDINGS

OF THE

TWENTY-SECOND ANNUAL SESSION

OF THE

Homœopathic Medical Society

OF THE

STATE OF PENNSYLVANIA.

PHILADELPHIA, PA., September 20th, 21st, 22d, and 23d, 1886.

THE Society was called to order at 8.16 P. M. by the President, DR. DAVID COWLEY, of Pittsburgh. Prayer was offered by the REV. E. J. SCHRACK, of Philadelphia, after which DR. J. N. MITCHELL, President of the Philadelphia County Society, delivered the following address of welcome on behalf of the County Society:

MR. PRESIDENT, LADIES AND GENTLEMEN:

As President of the Philadelphia County Society, it becomes my grateful duty to utter the words of welcome that usher in this meeting—a meeting which promises to be a momentous one.

It may seem to you like a work of superogation to speak to you of the cause of the change of our meeting place from Pittsburgh, since the building in which we are gathered this evening speaks for itself and tells its own story, silently, but with greater eloquence

than any words of mine can; but we wish thus publicly to speak of, and express our appreciation of the courtesy extended by our brethren of Pittsburgh to us.

Since the first meeting that inaugurated this Society, there has been none more important, none pregnant with matters of greater and more widespread interest than this one, during which we invite you to take part in the Dedication of the New College Building and Hospital.

We take great pride in exhibiting to you this Building, and our pride is greater because, that, though it is in our city, and although we have built it, yet we feel that we simply hold it in trust, that it belongs to the whole State.

Unlike any other Hospital of this or of other cities, it will not simply benefit us in its immediate vicinity, but will belong to and aid the cause of Homœopathy throughout our entire State,—yes, I may go even further and say throughout our entire country, for everyone who may send son or student here will reap of that which we have sown.

With these facts then before us, with the eyes of Alumni from all parts of the country upon us, with visiting Alumni and other distinguished guests from other States taking part in our proceedings, with the fervent belief that the completion of this New College and Hospital opens up a new and important era in Homœopathy throughout the whole State, do I err in speaking of this meeting as one of such momentous importance, and are not we authorized in our invitation and the hearty welcome we extend to you for being present with us this week?

Dr. Cowley then responded on behalf of the visitors as follows:

The first time I heard of a homœopathic doctor was about forty-five years ago. An old lady used to come into our house evenings to sit and chat. One evening she said, "The Hunters have a new doctor, they call him a 'homopatrick' doctor. He gives little powders, they are all white. I tasted one of them, and I believe in my heart *'tis nothing but sugar.*" At that time there was one homœopathic physician in Pittsburg (Dr. Reichhelm), and none in Allegheny.

Some five years later I was cured by some of the same doctor's

sugar powders. After this, although employed in a drug store in Pittsburg, I had faith in the new treatment. I found in the drug store "Hering's Domestic Physician," "Laurie's Practice of Homœopathic Physic," and a large number of very small vials, each containing a large number of very small pellets of the 30th potency of the most commonly prescribed homœopathic medicines. Whenever I had any ailment which seemed to require treatment, I consulted one of the homœopathic books, took some of the pellets, and was generally helped in a short time; for anything beyond my reach, I applied to one of the four or five homœopathic physicians then in Pittsburg; *now there are about fifty.* When I concluded to study medicine, homœopathy was the only system I thought of studying. I came to Philadelphia and attended lectures at the old college building on Filbert street, in 1851. About 125 students attended this college, the largest class which had up to this time assembled. Compared with the hundreds attending the old school colleges of the United States, this was a very small number. Now there is a great change, though we cannot say that the picture is reversed, and that there are more homœopathic students than allopathic, yet there is a *great* change. While the Homœopathic College of Pennsylvania, with its few students, and the Cleveland College, just started with its few, were the only homœopathic colleges in the United States and in the world; now there are fourteen colleges. While then, there was *no* hospital in the United States at which patients could be treated homœopathically, now there are over fifty; while then, there were not more than a few hundred homœopathic practitioners in the whole United States, principally in the large cities, now there are 10,000. Besides, the influence of the practice of homœopathy on the people and the medical profession, has so changed *everything*, that bleeding is almost unheard of, parvules and dosage tablets and small powders have taken the place of large pills and boluses and draughts. The so-called "regulars" then held themselves aloof from contamination with the "knaves or fools" who practiced homœopathy, that mostly they would hardly speak to a homœopath. If one of them did condescend, he looked all about him to see that he was not observed; *now* they are fighting among themselves for the privilege of consulting with the homœopaths. After those who wish to have the privilege obtain it, *which they*

will do, the question will still be unsettled, "Will the homœopaths consult with *them?*"

For this old *Alma Mater* of ours, we will say that she has been not only a mother to *us*, her immediate graduates, but also a mother to many of the colleges, who, with her, propagate the doctrines of homœopathy. Indeed, I think if the matter were well looked into, it would be found that she is more than a mother: she is a grandmother, perhaps a great grandmother; yet she shows no signs of decay; rather like what Swedenborg related of *old* women in the other world, who have led a good life in this one, she is becoming young, she is renewing her youth. She is ready to become the mother of hundreds, nay, thousands more; instead of the old-time number of seven professors and a demonstrator of anatomy to teach her children, she presents us with a force of ten professors, ten lecturers and four demonstrators, besides a hospital and dispensary staff. Instead of the old inconvenient, cramped building on Filbert street, she displays this roomy, new one. Young men who wish to do so (and old ones, too) can learn almost anything pertaining to medicine here. The limit to learning will be the capacity and time at command of the pupil, rather than the ability of this good old *Alma Mater*. We, therefore, bespeak for this college generous support and encouragement. If there are differences in our ranks, particularly in this city, let them be sunk out of sight for the good of the cause. Although I have reason to believe that homœopathic physicians, taken as a body, are more honest and more progressive and more intelligent than the body of practitioners of the old school, yet there is a great deal of "human nature," bad human nature, too, among the homœopaths. Enlightened selfishness, however, if nothing else, ought to induce us to work together for the good of the cause, and if we cannot *work* together, let those who cannot, place as little hindrance as possible in the way of those who can. Especially ought the hospital and dispensary to be supported, not alone for the benefit of the recipients of their bounty, though that is very important, but for the spread of confidence in the community in the advantages of the system, and also as long as the college exists for the practical training of students and young practitioners.

In reference to the change of the place of meeting from Pittsburg,

to Philadelphia, at the request of the College authorities and the Society of Philadelphia County, I would say that the change was made by unanimous vote of the members. The county societies of Allegheny and Philadelphia voted for the change; then the scattered members were corresponded with. The vote was unanimous, showing that there is a feeling of good-will prevailing in this State for the college, and that the Society of the State is anxious, by meeting here at this time of the dedicatory exercises of the new college and hospital buildings, to show its appreciation of the work of those who have charge of the college and hospital.

Dr. W. H. Bigler, the First Vice-President, then took the chair while Dr. Cowley delivered the

PRESIDENT'S ANNUAL ADDRESS.

Fellow Members:—According to provision of the By-Laws of the Homœopathic Medical Society of the State of Pennsylvania, it becomes my duty as President, to deliver an address at the opening of the session.

To some extent, this task is a difficult one, so many addresses before the American Institute, our own and other State Societies, and other public bodies have been delivered, that nearly all subjects pertaining to the interests of homœopathic medicines, to surgery and the allied sciences, have been so well brought before the profession, that it is rather difficult to find one which is very new.

Yet there remains much to be said and done. Taking into consideration the number of diseases afflicting humanity and the number of remedies possible with which to combat them, the relations of physicians to each other and to the public, we may on the other hand conclude that there is thought and work sufficient for thousands of physicians through ages of time. This brings my task to something like the following, viz: to present as useful an address to the Society as can be done in the space of time allotted, by one whose powers of thought and investigation are limited, while the subject is practically unlimited. To the best of my ability then, your attention will be directed to a few subjects which seem to me of importance.

It has been usual to present before the Society, statistics show-

ing the growth of Homœopathy from time to time; this subject will not be entered upon, as it has been so well done by Dr. Runnels in his address before the American Institute, and by Dr. B. W. James in his report to the International Homœopathic Convention, in August last.

While reading the report of the International Convention, it occurred to me, "what a contrast there is between the progress of homœopathy in America and all other parts of the world!" The paternal, fostering care of the governments of the old world may be credited with keeping down, almost smothering, homœopathy there, while lack of care and lack of law may be credited with its advance here.

The lack of laws governing physicians and protecting the public against ignorance and imposture, has this *one* advantage—people recognize and patronize everything of benefit to them, according to their intelligence and opportunities, without let or hinderance. Notwithstanding this advantage to the public and all new systems of medicine, plans of treatment, &c., I have no doubt that just and liberal *laws* of the States and general government would be better for the public and the profession, than the lack of them. This brings up one subject which seems of importance for the interests of the public, as well as of the profession generally, *i. e.*, the separation of the *teaching* faculties of our colleges from the power of licensing physicians to practice. This plan has been advocated lately by Regent Watson, of the University of New York; was recommended by the Committee on Legislation for this society in 1882, and was one of the pet schemes of the late Dr. Hering.

The advantages of this plan would be the sending forth of a body of men better qualified for their duties, because more carefully examined by an entirely impartial board of examiners. It would also support the colleges in their efforts to elevate the grade of medical education, without loss of patronage. Some of the colleges have complained of this, as the result of their praiseworthy efforts to that end. If necessary, the examining boards could be mixed; partly allopathic, partly homœopathic; but still better might it be to have separate boards for the different schools.

The consideration of this subject brings us to another which

ought to be taken charge of by the Committee on Legislation, and brought before the Legislature.

There have been bills for the regulation of physicians; there ought to be others for the regulation of the people and protection of physicians. Physicians should be secured in their right to remuneration for services. In this State, a man may have hundreds or thousands of dollars in his pocket or in bank, the physician may render him or his family valuable services for which he may receive no compensation. This is not just to physicians, and for several reasons, is also against the public welfare.

The physician who is absorbed in the duties and studies of his profession ought not to have his mind troubled with the cares of collecting money, not even through a collector. The physician ought not to be placed in the same category with the business man. Reward for his services should be secured to him by special laws, so that he can be free to devote his time and energies to acquiring greater skill in his profession and thereby benefiting the public. Of course such laws should be just to the public as well as the profession, that the public may be guarded against the rapacity of unscrupulous medical men. This might involve the regulation of fees, as is done in some countries.

Another matter which ought to engage the attention of our Committee on Legislation and which has been suggested by the chairman of that committee, Dr. H. Pitcairn, is the effort to have one or more insane asylums in the State placed in charge of homœopathic physicians. It is stated that the hospitals do not suffice for the needs of the many insane, and that new hospitals or additions to those already in existence, must soon be built. One or more of these ought, by right, to be placed in our charge. This subject has been brought before to the notice of this Society.

Another subject, which it seems to me, requires the attention of the Committee on Legislation, as well as the Bureau of Sanitary Science and State Board of Health, is the regulation of hours of work and rest for railroad engineers, brakemen, switchmen and telegraph operators, connected with the railroad service. Not on account of the *health* of these men, though this is of importance to them and the community, but because of their relation to the safety of the travelling public. This matter comes under the very

good rule laid down for their guidance by our State Board in their address of last year to the people of Pennsylvania, as follows: "It further conceives one of its paramount duties to be, to see that no man, or combination of men, however rich or powerful, shall be allowed to trespass on these rights of the humblest citizen, whether from negligence, from greed of gain, or simply from ignorance." The railroad companies *have* endangered the lives of the travelling public and probably will do so again by compelling engineers, brakemen, switchmen and telegraph operators to work more hours in the twenty-four, than is possible for men to do and retain control over brain and muscle. Who has not heard of engineers asleep in the cab, brakemen asleep on the cars or in their caboose, switchmen asleep at their posts, and telegraph operators sending wrong messages? All the result of fatigue and loss of sleep! The consequences of inability to discharge the duties entrusted to these men have been frightful. No doubt the officers of the railroad companies endeavor to do their best for the travelling public and the companies; but there are temptations for all of them to overstep the bounds of prudence, and it ought not to be left to the railroad companies to determine how many hours in the twenty-four, men in such responsible situations should work, neither ought this matter be left to the employees; there ought to be a law regulating hours and a penalty inflicted on railroad officers and on the employees, when overwork is required and done. There should also be a penalty inflicted on the men who, when opportunity for rest is given, do not accept it, but occupy themselves in pleasure or work unfitting them for their proper duties.

The regulation of hours of work and rest for railroad employees should be attended to, if possible, by the general government, and could be brought to the notice of the United States Board of Health by the State Board or by our committee on legislation.

Bills regulating physicians' fees, and securing them in their rights of remuneration, could be passed by *this* and other States. Co-operation of all other physicians with those of the Homœopathic faith and practice could probably be secured for these objects, as they are of general interest.

It has been suggested by our Corresponding Secretary, Dr. Bartlett, that the Bureau of Materia Medica should not be changed every

year as has been the case heretofore, but that the bureau members should be continued in their position for several years—say *five*. The suggestion is a good one. More effective work can be done by continuing the same set of men for several years, particularly in proving remedies and study of remedies so necessary to bring out the peculiarities of each one.

It has also been suggested that more time at our meetings be allotted to the discussion of subjects of especial interest to homœopathic practice proper, rather than to other matters. In the early days of homœopathy, the discussions were mostly on materia medica and practice, surgery, obstetrics, gynæcology, ophthalmology, &c., received comparatively little attention. Indeed, these subjects were largely neglected, but within the last twenty years those who believe in the homœopathic law have taken them up and applied the law with success in many directions not thought possible before. Thus many of the specialities of practice have been largely rescued from the hands of those who formerly claimed a monopoly of them, and scorned the idea of their treatment by homœopathy. It is to be hoped that this suggestion will receive as much attention from the members of the Society as possible, and that specialists in every branch, will endeavor to apply the law of similars wherever possible, and give the Society the benefit of their discoveries. Of course, as time passes and the number of homœopathic physicians increases, the efforts of our members will reach out with wider scope, and original research in other fields than those proper to homœopathy will become common. Of course all subjects pertaining to the cure of disease, ought to receive attention, for the "object" of this Society is a wide one, it is "*the advancement of medical science*."

I now approach a subject which it has seemed to me my duty to present before this Society. In the Providence of the Lord you selected me for your President; the by-laws make it obligatory on me, as President, to make an address. I have cudgeled my brains to produce something in this address which would be useful to you. You may not agree with me as to its utility, but, as far as I can see, this is one of the most useful subjects which has ever been brought to your notice. I refer to the *scientific and philosophical methods and teachings* of Emanuel Swedenborg. To most of you

who have heard of Swedenborg only as a visionary and the founder of a religious sect, it will seem strange to have him held up as a scientific explorer, discoverer and teacher, but nevertheless these titles are claimed for him by many *scientific* men, as well as by those who accept his religious dogmas. To-night, I present his claims for consideration; not for the purpose of glorifying the man, or calling attention to the theological and religious system promulgated by him, but for the purpose of bringing to your notice scientific theories and doctrines which are comparatively new but true. If this is so, those who first comprehend and carry into practice these doctrines will be most benefited themselves, and will most benefit others. For all truth can be made of use to mankind. In the line of the methods of investigation pursued by Swedenborg, I verily believe lies the advancement in the future of psychology, physiology, pathology and homœopathy; in short, all the sciences.

When these scientific methods and doctrines are applied to homœopathy, we will gain power to cure disease hitherto unknown.

That you may have some idea of the importance of Swedenborg's scientific, philosophical and physiological teachings and of their divergence from those usually taught, I will quote some from writers who are not believers in his religious views, who may, therefore, be regarded as impartial, even antagonistic, but who yet give a fair view, as far as it goes, of his scientific system. I intended in this connection first to quote from "Morell's History of Modern Philosophy," but as it will consume more time than is at our disposal, and possibly weary you, I will refer those who feel interested in the subject to that book, American Edition, 1854, published by Robt. Carter & Bros., New York, pages 202 to 206.

The quotation which I will now read is from a review of the first volume of Swedenborg's work on the Brain, and though it does not show up in detail his scientific and philosophical doctrines, yet it gives important and interesting results of the application of those doctrines.

Review of Swedenborg's Work on the Brain, by A. Rabagliati, from October number, 1883, of "*Brain*": A Journal of Neurology. London: Macmillan & Co.

"This is without doubt one of the most remarkable books we

have ever seen, and perhaps to a great extent, on that very account, it is a very difficult task to criticise or review it. The distinguished author lives in history more as the founder of a form of religious thought than as a scientific man, and yet it is a fact that he was eminent as a mathematician, as an engineer and as a mineralogist and geologist. Still, it is a new experience to find him figuring as the writer of a work on the human brain, and still more curious to discover that, although that work has lain by for nearly a century and a half, it is now not only not valueless, but it appears actually to have anticipated some of the most modern discoveries in the region of its subject-matter. Only the first volume of this remarkable work is before us, but we are bound to say that the prevailing feeling forced on our minds during its perusal has been one of surprise at the great power and profound philosophical insight of the writer, as point after point of his argument has been brought into view. No doubt, to Swedenborg, this work had mainly a theological interest. He was over fifty years of age when he wrote it, but it was about this time in his life that he directed his energies mainly into those lines from which arise his claims to live in the temple of fame, and the remaining thirty years of his life were employed in elaborating the views he had already formed. This fact undoubtedly makes it more difficult to gauge the value of the work, because for us it has only a scientific interest, and it is therefore necessary to unravel, and, so far as possible, to confine to its rigidly scientific bearing the phraseology, now metaphysical, now ontological, now theological, of which the author makes use. And indeed, we may say that if it had not been that attention was arrested and interest enchained by finding so many anticipations of scientific discoveries by as much as one-hundred and twenty or one-hundred and thirty years, we should be tempted to throw aside the book as beyond our province, if not hopelessly unintelligible. For it is difficult to deal scientifically with such expressions as 'essences of a superior and inferior kind,' 'the ideal of the universe which is below,' the supreme in 'every system of the soul,' and such as 'series determined into higher and lower spheres,' with other like phrases which occur from time to time.

"In order, however, once for all, and so that repetition may be avoided, in order to make, as it were, the transition from Sweden-

borg's ontology to the scientific sphere, in which alone for the purposes of this review we are interested, it seems necessary in the briefest manner, to make some remarks which shall show at once the nexus and the separation between the two. Swedenborg assumes all through his writing the existence of the soul, which, according to him, has its seat in the minute parts (each as it were a smallest brain with its own vessel, its own gray substance, and its own fine membrane) of the cortical substance; and he always assumes, because he saw or felt it as an innermost conviction that the soul was the representative of God in the universe. This is, of course, a position, not unscientific indeed, but extra-scientific; that is to say, outside the sphere of science. If it is a true position; if, that is, the soul is a *vera causa* or real existence, scientific inquiry will not indeed reveal results incompatible with its existence, this it cannot do if Science keeps to the truth of phenomena, which is always her aim, but the phenomena with which alone Science has to do will not and cannot reveal the presence of a *vera causa* like the soul, for this is not a phenomenon, but an existence *per se*. Language of an ontological character, therefore, used by a man who, like Swedenborg, was essentially an ontologist, or a man who strove to reach the domain of things in themselves, such language may fairly enough be studied by the man of science, that is, by him who, for his present purpose, confines himself entirely to phenomena. All that the scientific man has to do—it is a thing simple enough in theory, though difficult in practice sometimes—is to make and repeat the mental reservation where ontological phrases are used, that the ontological assumptions are a method of explaining the phenomena which may or may not be correct, but that the subject-matter of science is only the phenomena.

"This kind of correction, however, is not peculiar to the kind of consideration we have instanced; to views, that is, concerning the soul and God. It is fundamental to all science and to all philosophy, and in point of fact, it is the consideration which in principle lies at the bottom of the division of the domain of philosophy into two schools, the intuitional and the experimental.

"An instance or two will explain our meaning before we pass to the scientific side of Swedenborg's views concerning the brain. In causation, science knows only succession, or, perhaps, invariable

succession; but invariability itself can be predicated only experimentally, that is to say, that it always has been so, but theoretically, there may be an exception any day, though no one expects that there will be. Necessary connection, science never can predicate, because necessity is not in phenomena, but only succession, invariable within the limits of experience. The same considerations apply to the power assumed to lie behind the phenomena of causation, as Hume's billiard balls proved to all the world in Swedenborg's own day. The scientific reader who is at all acquainted with the history of philosophy, will at once recall many other instances of terms used freely by science, which are calculated to raise similar questions. Matter, force, energy are some of them, as well as those we have mentioned, and it is curious to observe that though, properly speaking, these are philosophical terms, it is science which has been responsible for the very much wider currency which of late years they have obtained. Of course, where Science does make use of them, it ought fairly to be only as general names and for the purpose of avoiding unnecessary repetition; but it is full of instruction to analyze the very various uses scientific men make of such terms, and to trace out the large and even appalling amount of very loose thinking which they frequently cover. But (and this is most important) for the very reason that *veræ causæ*, like God and the soul, can never appear as phenomena, for this very reason science can say nothing about them, least of all can she say they do not exist. If they do exist, she cannot see them, because her vision does not extend so far; they are out of her range.

"The questions relating to their existence are questions not for her at all, but for ontology, or for philosophy; so true is it that the metaphysical questions are after and also beyond the physical, the phenomenal, the scientific. We do not say what weight should be attached to the fact that terms involving reference to ontological considerations are continually arising out of science. Nor do we attempt to raise ontological discussion on them. Our present purpose is only to show what we, therefore, repeat, that such a *vera causa*, as the soul, assuming its existence, can never appear in phenomena. But the language of him who assumes a *vera causa*, because by the eye of reasoning he sees it, will be intelligible to

the scientific man who refuses to transcend the phenomena, provided he always keeps in mind the difference that exists between phenomena and the modes of accounting for them by the assumption of independent existing *veræ causæ.*

"II. *Swedenborg's Anticipation of Modern Discoveries.*

"The following are some of the views held by Swedenborg on the brain and its functions, and the statement of them will show both how frequently he anticipated modern discoveries and also how many of his opinions are still, more or less, peculiar to him and his followers. If time and space permitted, it would be very instructive to inquire in how many of these views Swedenborg was correct, or how far, at least, the evidence appears to justify the conclusions to which he came. Some of this evidence will be referred to in this review, but it will be impossible to take up all the points, interesting and important though some of them undoubtedly are:

"1. Swedenborg taught that the motion of the brain is coincident with respiration, not with pulsation. The origination of this view is now universally (that is, so far as it is held, for many physiologists of the present time do not seem to know of it) attributed to J. Daniel Schlichting, a physician of Amsterdam, who wrote in 1750; but Swedenborg wrote between 1741 and 1744. We propose to devote some space to the discussion of this view of Swedenborg, because it is fundamental to his opinions, and because the most elaborate and learned note of Dr. Tafel enables us to do this in a most complete way. We will at present, therefore, only say that the complete statement of Swedenborg's position on the subject is, the *dura mater* undoubtedly pulsates with the movement of the heart, but that the underlying brain as undoubtedly moves synchronously with the respiration and not with the pulsation of the heart.

"2. Swedenborg held that the respiratory motion of the brain and lungs extends to the extremities of the body. This discovery is generally attributed to Dr. Piégu, who wrote in 1846.

"3. Although Swedenborg taught that the movement of the brain was synchronous with the respiration, he also held that it is independent of it. This point will be discussed in our general review.

"4. Any student of Swedenborg will see that the term 'animal

spirit,' so frequently used by old anatomists and old philosophical writers, is an expression not used only of a metaphysical idea analogous to soul, but of a veritable fluid, having an actual existence, and composed, according to Swedenborg, in a very definite way, and fulfilling a very definite function or purpose in the economy. We confess to having our conceptions much cleared in this particular by a perusal of the book.

"5. Swedenborg taught that the anterior part of the cerebrum is the seat of the intellect. This is precisely the view adopted by modern science.

"6. It is worthy of mention that Swedenborg's division of the brain is not quite that which obtains at the present time. His highest lobe is bounded by the marginal convolution and the quadrate lobule, his middle lobe by the lower part of the marginal convolution, and the gyrus fornicatus; and his third lobe is identical with the temporo-sphenoidal lobe. Keeping this in mind we find him making this statement: The 'muscles and actions which are in the ultimate parts of the body, and thus in the soles of the feet, depend more immediately upon the highest portion of the cerebrum; upon the middle lobe, the muscles of the abdomen and thorax; and upon the third lobe, those which belong to the face and head; for they seem to correspond to one another in an inverse ratio.' The general correspondence of these statements with the positions of the most modern science cannot fail to strike the reader.

"7. Swedenborg says 'the copora striata are vicarious cerebra, and they succeed in place of the cerebrum whenever it is deprived of the power of acting.' And again, 'The corpora striata initiate movements which at first originated with the cerebrum and were voluntary, for it is a well known fact that voluntary acts by daily habit become spontaneous, or that habit is like second nature.' This language again is strikingly like that of modern science.

"8. So also Swedenborg showed the connection of the corpora quadrigemina with the sense of sight; and also what we may shortly call the commissural arrangement of the corpus collosum.

"9. Key and Retzius have shown (1875–76) that the choroid plexuses of the lateral ventricles are made up of two leaves, of which the upper comes from the fimbria of the fornix and the

lower one partly. Strange to say Swedenborg said very much the same thing one hundred and thirty-five years before.

"10. Swedenborg says that in order that the brain may be relieved of the liquid which is perpetually expressed from its membranes and arterial vessels, the above liquid passes into the cavities of the nose through the openings in the cribriform plate of the ethmoid bone. This position also, though it is not acceptable by medical men or physiologists, appears to have been corroborated by experiments made by Key and Retzius.

"On this we will only say, since space does not allow of our discussing the question fully, that there are cases coming from time to time under the notice of the medical man, which appear to corroborate Swedenborg's statement. Patients frequently say (we have met such) that they are subject to a form of attack accompanied by pain in the frontal region, generally brought on by mental over-work, and simulating a cold in the head. Such attacks pass off, and relief is at once experienced on the appearance of a clear discharge from the nostrils. Such persons have assured us that they were also subject to attacks of nasal catarrh, and that they could perfectly distinguish between the two, but that the attacks now spoken of were quite different, and that in their opinion, the fluid comes from the inside of the head and not from the nasal mucous membrane.

"11. Swedenborg held that the active parts of the brain are the cortical subtance, and that the brain is made up of as many similar forms and natures as it has discrete cortical parts. And further, that the cortical substance is so connected with the minute vessels of the brain that you would believe that the cortical glands derive their origin from the vessels. Swedenborg did not say that he had seen this structure, but, reasoning from analogy, he felt certain of his position, that the cortical glands hang down, and sprout forth from the sides and coatings of the producing and generating arteries, scarcely otherwise than as grapes and berries are wont to hang down, etc. Dr. Bevan Lewis, writing in 1877, says, from his microscopic investigations, that a minute blood vessel invariably runs in close contact with all the large nerve cells; and that the peri-cellular sacs are laterally disposed along the sides of the smaller capillaries, in no case occupying a terminal

position. This is a remarkable corroboration of the truth of Swedenborg's statements.

"*III. Respiratory Brain Motion.*

"Lastly, Swedenborg's method of inquiry, and the conclusions at which he arrived appeared to him to demand that some foramen or foramina must exist at the base of the fourth ventricle, through which the cerebro-spinal liquid is discharged from the ventricle; and they also seemed to him to require the presence of a channel from the fourth ventricle into the spinal cord. Since Swedenborg's time a foramen in the former position has been discovered, called the foramen of Magendie, and also in the latter, where it is known as the central canal of the spinal cord.

"As regards propositions 1, 2 and 3, on the Motion of the Cerebrum, no mention whatever is made of this by such modern physiologists as Todd and Bowman, Carpenter, Michael Foster, Draper, Flint, Hermann or Ferrier. So that, speaking generally, we may say the view is not held by modern science. And yet Rialdo Colombo (1559), Bartholin (1673), Wepper (1681), Vieussens (1685), Baglivi (1701), Ridley (1703), Bellini (1714), Pacchioni (1721), and Fantoni (1738), all of them literary predecessors of Swedenborg, had held and taught this view.

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"The motion of the brain being thus established as a fact, the next consideration is of what sort is that motion? Up to the time of Swedenborg, although, as we have seen, there was no doubt about the motion (which was doubted only after his time), it was universally (?) held that that motion was coincident with pulsation. Swedenborg's views led him to the conclusion that it must be coincident with the respiration. He knew well enough that there was a motion of the brain coincident with pulsation also, but that motion he held was due to the dura mater, or rather to the outer layer of that membrane. The movement of the inner layer of the dura mater, on the other hand, corresponded with the motion proper to the brain, and was coincident with the respiration. Now, in these particulars, it is very remarkable that later discovery has entirely justified Swedenborg's views. Some time ago the present writer abstracted for "Brain" Professor Masso's work on the motion of the brain, referring at length to the tracings obtained

from that motion by the graphic method of Professor Marcy. There is, therefore, the less reason to do here more than to refer to his work, but it may be said that the labors of all the inquirers, by means of Professor Marcy's graphic method—a method about which there can be no mistake, since it is really self-registering—coincide in showing changes in the volume of the brain coincident with the respiration. There is no doubt about the pulsatile movement of the dura mater, but coincident with this, there is also observed a heave and fall of the curve corresponding with the respiration. Dr. Tafel reproduces in his note, tracings from Salathe (1876), Francois Frank (1877), and Masso (1881), which show this double motion beyond dispute. Nor is there any more inherent difficulty in understanding how such a double movement may take place, than in understanding what every one knows, that the heavenly bodies have a movement round a centre, such as the sun, at the same time that they revolve on their own axes.

"IV. *Respiratory Motion of the Brain Self-originating.*

"Swedenborg held that the respiratory motion of the brain, although coincident with it, was not due to the respiration, but was inherent in the brain itself. Here, also, modern science confirms Swedenborg's position, for Prof. Masso shows that a change in the pulse of the change (observed in the dura mater) does not depend by any means upon a change in the movements of respiration.

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"Arising out of Swedenborg's views on the self-originated respiratory motion of the brain, naturally follows his position concerning the government of the cerebral arteries, which according to him, are emancipated from the government of the heart, and have their blood current moved in the stream of the animatory motion of the brain, which is synchronous with the respiration.

"There are three facts which corroborate the truth of Swedenborg's position, or, we may even say, prove it. First, the brain and cerebellum are supplied by the internal carotids and vertebrals, while the arteries of the dura mater come from the external carotids. Second, the internal carotids and vertebrals undergo a remarkable series of twistings, just before entering the brain, which can have the effect only of breaking the force of the blood cur-

rent, and emancipating the vessels from the heart's impulse. And, thirdly, they lose their muscular coats, and become dilated into various ampullæ, which must have the same effect on the circulation contained within them. An examination of such modern writers as Quain, Carpenter, and Key and Retzius, tends strongly to confirm the truth of Swedenborg's views in this particular.

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"A quotation from Swedenborg himself will fitly bring this review to a close. It places his theory in a harmonious manner before the reader, and also states, what we have made only the most incidental reference to, his view as to the course taken by the animal spirit or fluid secreted by the brain acting in its glandular capacity: 'It is absurd to suppose that any action can begin in the middle of a fibre and not in its first terminus. If, then, it begins in the first organs, it must inevitably begin in the cortical glands' (or nerve cells) 'for the fibres commence, and are conceived and produced in those glands, and the arterial vessels of the brain terminate also in them. Hence if the principles of motion exist in them, according to all physical and philosophical laws, as mutually confirmed by and confirming each other, those principles must necessarily commence by a kind of active, living, locomotive reciprocal force, that is, by a kind of expansion and constriction or systole and diastole, such as we observe in a gross form in the lungs and heart; for the same conditions are involved, whether the spirit is to be driven through the fibres, or the blood through the vessels. The blood cannot be driven through its arteries, without the reciprocal expansion and constriction of the heart; nor can the spirit be driven through the fibres, which are little canals and vessels analogous to the arteries, only more pure, without the reciprocal expansion and constriction of the cortical glands of the brain, which, on this account, deserve the appellation of pure corcula or little hearts. Assuming, or granting these points, the necessary consequence is, that every time the cortical and cineritious substance of the cerebrum, cerebellum, medulla oblongata, and spinal cord contracts, or constringes itself, the whole mass of these parts sinks down, and undergoes systole; but, on the other hand, undergoes diastole, when the same sub-

stance, I mean the whole congeries, expands. This is the animation of the brain, using the term brain in its widest acceptation, that corresponds to the respiration of the lungs. We must now proceed a step further. If the animal or nerve spirit, at the interval of the constriction of these organic substances, of the little hearts, of the cerebrum, is expressed by the cerebrum through the nerves and nervous fibres, of course, it is expressed by the cerebellum into its grand sympathetic nerve, and the great sympathetic cords; and granting this, it follows that these nerves act during the same intervals upon the fibres of the pulmonary plexus, and upon the fibres of the costal nerves; which cannot fail on the instant to act upon their muscles and membranes; nor the latter to act upon the ribs, and thus upon the internal structure of the lungs. Hence it follows that the animation of the brain (using the term here again in its widest sense) must necessarily be coincident with the respiration of the lungs; and the fact is still more plainly declared by the influx of the fibres of the above mentioned cerebellar nerves, the pneumogastric, and the great sympathetic, into all the viscera of the abdomen; and by the motions of those viscera agreeing exactly, and keeping perfect time with the respiratory motions of the lungs.'

"No doubt there is here a mixture of scientific and metaphysical considerations, although the former largely preponderates; but we venture to say that the scientific reader who takes up the book will feel it well worth his while to separate the one from the other, as we have attempted to do, and that he will admit that the method of a writer, who, so long ago, could make contributions to brain physiology of so permanent a value, must have some qualities that entitle it to attention."

In conclusion, I would thank the members for the honor conferred upon me and for their attention this evening.

I would also ask their forbearance should I sometimes fail to expedite business as rapidly as possible or should I render decisions not strictly parliamentary. I have no doubt the aim of all will be to have as much work done as possible, to spend as little time on routine business and as much as possible on scientific and practical discussion. If I err I hope my fellow members, who "know better," will give me their counsel.

Dr. John K. Lee, of Philadelphia, then moved that a vote of thanks be tendered the President for his address, and that a committee be appointed to consider the suggestions contained therein. Carried.

The Chair appointed as the committee on the President's address Dr. Pemberton Dudley, of Philadelphia, Dr. J. B. Wood, of West Chester, and Dr. J. A. Bullard, of Wilkesbarre.

President Cowley then resumed the chair.

The calling of the roll was proceeded with.

The Treasurer, Dr. J. F. Cooper, of Allegheny City, then submitted his report as follows:

REPORT OF THE TREASURER.

To the Homœopathic Medical Society of Pennsylvania:

Balance due the Treasurer at last report, .	$ 95 40	
Paid Sherman & Co. for printing and binding transactions of 1885, ...	409 00	
C. Bartlett's bill of September 25th, 1885, . .	39 61	
" " " February 12th, 1886, . .	24 92	
300 2-cent stamped envelopes for Treasurer's use, August 30th, 1886, ...	6 66	
		$575 59
Received as dues of membership since last report, ...	$475 00	
Proceeds of sale of three copies transactions of 1885, ...	9 00	
Balance due the Treasurer, ...	91 59	
		$575 59

This report was, upon motion, accepted and referred to an auditing committee, consisting of Dr. Z. T. Miller, of Pittsburgh, and Drs. B. W. James and H. Knox Stewart, of Philadelphia, who presented the following report:

REPORT OF THE AUDITING COMMITTEE.

To the Homœopathic Medical Society of Pennsylvania:

The undersigned, appointed to audit the above report of the Treasurer, have examined the same and find it to be correct.

Z. T. Miller, M. D.,
B. W. James, M. D.,
H. Knox Stewart, M. D.

The Corresponding Secretary, Dr. Clarence Bartlett, of Philadelphia, then presented his report.

REPORT OF THE CORRESPONDING SECRETARY.

To the Homœopathic Medical Society of Pennsylvania:

During the year just past your Corresponding Secretary has received numerous letters from physicians residing beyond the limits of our State, making inquiries as to how to procure our annual volume of Transactions. We have been in the habit of printing only enough volumes for our own use, hence we cannot undertake to supply physicians residing in other States. Your Secretary would recommend that a committee be appointed who shall consider this matter and suggest some plan by which non-resident physicians may obtain our Transactions by becoming either members or annual subscribers.

Your secretary would call your attention to the large number of back volumes of the Society's Transactions now on hand. The following is an approximately correct inventory of these: 32 complete sets, from 1866 to 1873 inclusive, 80 copies of 1868, 35 of 1870-71, 70 of 1872, 86 of 1873, 134 of 1874-78, 60 of 1879, 94 of 1880, 30 of 1881, 50 of 1882, 42 of 1883, 64 of 1884, and 81 of 1885. Your secretary would suggest that some action may be taken by which these volumes may be purchased at a reduced figure, by such members as desire a full set of our Transactions.

The total expenses of this office, including the programmes and notices of this meeting, for the past year, were $46.22.

Respectfully submitted,

CLARENCE BARTLETT, M. D., Cor. Sec'y.

This report was accepted and referred for publication. On motion, a committee, consisting of Drs. J. F. Cooper, J. B. Wood and C. S. Middleton, was appointed to consider its suggestions.

The report of the Publishing Committee was then presented by the Corresponding Secretary, Dr. Clarence Bartlett.

REPORT OF THE COMMITTEE ON PUBLICATION.

To the Homœopathic Medical Society of Pennsylvania:

Your committee would report that the transactions of the last annual session were issued in an octavo volume of 282 pages.

bound in muslin, in style uniform with those of preceding years. The volumes were ready for distribution early in December, but owing to unavoidable circumstances, were not placed in the hands of the members until the last week in that month. Three hundred copies were issued at a cost of $409.00. One hundred and sixty copies were sent to members, twenty-four to medical journals, twelve to Homœopathic Colleges, nine to public and hospital libraries, and eleven to other State Societies. Three copies were sold, leaving a balance of 81 copies on hand.

CLARENCE BARTLETT, M. D., *Chairman.*
HORACE F. IVINS, M. D.,
J. F. COOPER, M. D.

The Committee on Legislation reported verbally through Dr. Hugh Pitcairn, its chairman.

REPORT OF THE COMMITTEE ON LEGISLATION.

To the Homœopathic Medical Society of Pennsylvania:

He suggested that the only duty of his committee was now to watch the interests of homœopathy, by watching our representatives, and at the proper time to put in an application for an appropriation for an insane asylum, to be under the care of the homœopathists, as suggested in the President's address.

DR. B. W. JAMES wished to know if anything had been done to find out how this could be best accomplished, and referred to the great improvements which have recently taken place in Rhode Island, due to the appropriation by the Legislature, and thought that this was a good example and a good precedent to other States. He thought that the committee should make a great effort as well as should this society, so that we should have a large insane asylum in this State and under the care of the homœopathists.

DR. J. K. LEE, Philadelphia, said that as a member of the Board of Public Charities he would recommend the appropriation as soon as there was any money in the treasury to pay for it.

DR. J. F. COOPER asked how the nucleus for the R. I. asylum was started.

DR. B. W. JAMES said that the government gave a large tract of land as a nucleus, and later $180,000.

Dr. Cooper referred to the methods adopted by the New York men, in order to secure the Middletown Asylum.

Dr. Cowley thought the Board of Charities might be appealed to.

Dr. A. Korndœrfer thought we had been too modest in asking for money from the State, and that we should make our demands less modestly. The Board of Public Charities had refused to grant our application because, it stated, a hospital should not be run in conjunction with a college, and yet at the same time did grant such a privilege to another institution at the same session. He said we should insist more decidedly on the appropriation at the next meeting of the Legislature. The Doctor then referred to the amount of dispensary and hospital work which we homœopathists have done without State aid, save one grant of about $5,000.

Dr. B. W. James referred to the over-filled condition of our State insane asylums, and to the relief which it would afford these institutions if a homœopathic asylum could be formed by taking to a new building those who, in the older asylums, were inclined to homœopathy. This latter he made as a suggestion to the committee.

Dr. J. F. Cooper thought we had been well treated by the Legislature.

Dr. H. Pitcairn said there was no other way to have any influence upon the Legislature than by doing more active work, directed to the individual members of that body. As it now is, physicians will not leave their practices to go to Harrisburg.

Dr. Korndœrfer said that he and others had gone to Harrisburg, and that various members promised to do their duty, but when the time arrived, they failed to do so.

Dr. Pitcairn said that the committee from Philadelphia did not stay in Harrisburg and see the appropriation through. This the committee from Pittsburgh did, and they got their appropriation.

Dr. J. K. Lee referred to the non-presentation of the application to the State Board of Charities.

At the close of the discussion the report of the Committee on Legislation was accepted.

Dr. B. W. James moved that the foregoing committee should look to securing an asylum for the homœopathic treatment of in-

sane patients when the proper time for legislation should arrive. Adopted.

The report of the delegates to the American Institute of Homœopathy was not received, owing to their absence.

The society then adjourned until the following morning at 10 A. M.

On Tuesday, at 10 A. M., the society was called to order by the President.

Dr. W. J. Martin, of Pittsburgh, in the absence of the Necrologist, Dr. W. R. Childs, read

THE NECROLOGIST'S REPORT.

Since our last meeting the following members have died:

Prof. E. A. Farrington, M. D.
Jno. R. Reading, M. D.
Aug. W. Koch, M. D.
J. S. Pfouts, M. D.
Wm. Grumbein, M. D.

Ernest A. Farrington, M. D.—At our last meeting Dr. Jos. C. Guernsey offered the following resolutions concerning the illness of Dr. E. A. Farrington, which were unanimously adopted:

Whereas, The Homœopathic Medical Society of Pennsylvania now in session in Philadelphia learns with deep regret of the severe illness of our colleague, Dr. E. A. Farrington, which prevents him from meeting with us on this occasion,

Resolved, I. That we greatly miss his valuable contributions on materia medica; the able part he took in our discussions; and his genial and encouraging presence.

II. That we hope soon to learn of his complete restoration to health.

III. That the Secretary be instructed to forward a copy of these resolutions to Dr. Farrington.

December 17th we learn that the subject of these resolutions, Prof. E. A. Farrington, M. D., has passed away, and in this world we ne'er shall see him more.

Dr. Ernest A. Farrington was born January 1st, 1847, at Williamsburg, L. I., New York. At an early age, he completed and

passed a most creditable examination at the Philadelphia High School, standing at the head of his class. Under the preceptorship of his brother, H. W. Farrington, M. D., he in the fall of 1866 matriculated in the Homœopathic College of Pennsylvania. In '67 he was the second matriculant of the Hahnemann Medical College of Philadelphia. He graduated in March, 1868. His close attention to study having undermined his health, during the summer of 1869 he made a trip to Europe, from which he returned much improved. September 13th, '69, he married Miss Elizabeth Atkin, of Philadelphia. In 1874, upon the resignation of Dr. Guernsey, he was chosen to fill the Chair of Materia Medica, having previously lectured upon forensic medicine very satisfactorily. Here we find him filling the position which seems to have been specially allotted to him and one which all who have known him personally or through his writings have ever accorded he was most fitted for. We can here appropriately quote the words of the lamented Hering (the father of materia medica in this country) who was ever delighted to say "when I am gone Farrington must finish my materia medica." His writings all bear the impress of a master mind. His highest aim was to do right because it was right; that he accomplished this all who knew him will attest.

Dr. Farrington was a member of this our State Society and his papers were always listened to with intense interest and were considered choice contributions. He was also a member of the Philadelphia County Society, of the American Institute of Homœopathy, and in 1884 this body appointed him a member of its Editorial Consulting Committee on the new Cyclopædia of Pathogenesy. He was contributing editor for several years to the *Hahnemannian Monthly*. He was a man generous in his friendship, genial in his manners, beloved by the students he lectured to, admired by his professional brethren, conscientious, zealous and learned. It seems that one thus endowed should have been left long to pursue the good work which he was doing but alas we cannot look behind the veil. What seems mysterious now, when viewed from the other side will be found to be all right. His faith in Christianity sustained him even to the end.

The next death which we have to record is that of our second Vice-President, John R. Reading, M. D.

Dr. Reading was born in Somerton, Philadelphia, November 21, 1826. After his academic education he became a student of Dr. David James. His collegiate education was pursued in Jefferson Medical College of Philadelphia, from which he graduated in 1847. He soon after entered into partnership with his preceptor, and engaged in the practice of homœopathy.

In 1868 Dr. Reading was elected by the citizens of the Fifth Congressional District to represent them in the Forty-first Congress, where he served on the Joint Committee on Retrenchment. Dr. Reading was an earnest, devoted and distinguished member of the Methodist Church, and was for many years a licensed local preacher of that denomination. He was a senior member of the American Institute of Homœopathy, and had been a member of this our State Society from its birth in 1866. His death, which took place on February 14, 1886, at the age of fifty-nine years, was caused by attenuation of the ventricular walls of the heart, the remote cause having been a myo-carditis in early life, complicating pericarditis.

Of him it can be said, he was a man of refined and cultivated taste, of cheerful dignity, easily approachable by even the lowliest, a faithful and sympathizing friend, considerate and urbane in his manner always, a skillful physician, a devoted husband and father. A devout and uncorrupted Christian is what all who had the pleasure of his acquaintance will cheerfully bear testimony to.

August W. Koch, M. D., was born March 27, 1805, in Würtemburg, Germany. He attended a classical institution until his fourteenth year, when he entered a pharmacy. Here he remained four and a half years, and then was enabled to pass an examination and duly qualified as a druggist's assistant. He afterwards entered the University of Tübingen in Würtemburg. Four years later, he passed both the University examination for the degree of M. D., and that required by the State for his license to practice medicine.

In 1831, he began his practice as an allopathic physician in the town of Ebingen. Later, his attention was directed to homœopathy, and in 1834–5, becoming convinced of its truth from his own personal investigations, he began its practice. In 1836, in

pursuance of a call from some of the most influential homœopathic laymen of Stuttgart, the capital city of Würtemburg, he moved thither, and was soon in enjoyment of a lucrative practice there, besides being instrumental in firmly establishing homœopathy in that city. During his eleven years' residence there, he received from the South German Homœopathic Medical Society their prize for the proving of Calcarea Carbonicum and Calc. Caust. He was the first to introduce Iodine to the profession in the treatment of croup, and published in 1846 a book on homœopathy, besides being a faithful contributor to the medical journals of the new school. He was made honorary member of the Homœopathic Institute of Paris shortly before leaving Europe.

In 1847 he came to this country and settled in Philadelphia, where he continued to practice with success to within two years of his death, which occurred on May 4th, 1886. He was a senior member of the American Institute of Homœopathy, a member of the Philadelphia County Society, and of this society.

At the meeting held in Philadelphia in 1883 the following communication was presented:

PHILADELPHIA, PA., NOV. 18, 1882.

J. F. Cooper, M. D.;

DEAR DOCTOR:—Please have my name taken off the list of members of the State Society. My increasing age prevents me from enjoying any of the advantages of membership, and I therefore wish to withdraw. I have wished to take this step for a couple of years past, but it has always escaped my memory until the year was too far advanced. Yours fraternally,

AUGUST W. KOCH, M. D.

The society, by vote, unanimously declined to accept this resignation, and the Bureau of Organization, Registration and Statistics was instructed to prepare an amendment to the By-Laws which will allow the society to retain its veteran members free from all pecuniary or other obligations.

The following was then on motion adopted as an addition to Article IV., Section 1.:

"Any member who shall be unable to comply with the requirements of this section may be continued as an active member without payment of dues, by vote of the society."

This action is simply repeated three years afterwards to show in

what high esteem we held the valued and venerated member whose necrological report is now presented to you. Constantine Hering departed in his eighty-first year, August W. Koch in his eighty-second. Few of the elders now remain, let us cherish them while they live and revere their memories when they depart.

John S. Pfouts, M. D.—Born in Jersey Shore, Pa., July 13, 1829. Educatedat Dickenson Seminary, Williamsport, Pa. He entered the office of George J. Pfouts, M. D., in 1850. He pursued his medical education and graduated from the Pennsylvania Medical College of Philadelphia March 5, 1853. Forming the acquaintance of Dr. N. C. Moore, a homœopathic physician, he was induced to make an examination of the principles of homœopathy. The result was satisfactory. In 1854, he went to La Crosse, Wis., and began the practice of the new system. The climate not agreeing with him, he was compelled to come East, and after remaining at home for a year, he went to Columbia, S. C., where he was the pioneer of homœopathy. His practice here was very successful, but at the breaking out of the War of the Rebellion he was compelled to leave or take up arms against the Union. In the fall of 1861, he came to Wilkesbarre, Pa., where, amidst great discouragements, he recommenced practice, and succeeded by patient labor, in building up a business which, while yielding a handsome income, gave evidence of his skill and merit and of the progressive tendency of homœopathy. Dr. Pfouts became a member of the State Society in 1868.

William Grumbein, M. D., Annville, Lebanon county, Pa.

In regard to Dr. Pfouts and Dr. Grumbein I have not been able to gain any information except what I had already gained in reference to the first named from published records. I hope still to get some information for the Publication Committee.

Respectfully submitted,

William R. Childs, M. D., Necrologist.

THE REPORT OF THE BUREAU OF ORGANIZATION, REGISTRATION, AND STATISTICS

Was presented by the Chairman, Dr. Clarence Bartlett, and was as follows:

There are now about seven-hundred and fifty homœopathic physicians in the State, and yet there is room for more, for example there are towns in the State containing four-thousand inhabitants, and yet have no homœopathic physician. This should not be.

Important changes have been made at the Hahnemann Medical College of Philadelphia. The grand new edifice which has just been completed, will be inspected with pleasure and pride by all present at this meeting. Important improvements in the teaching have also been made. The three year's graded course has been made obligatory on all future matriculants. The number of instructors has been increased so that the students may acquire a thorough knowledge of the various specialties in medicine and surgery.

The Pennsylvania Homœopathic Hospital has ceased to exist as such. During the Spring of the present year, a merger between it and the Hahnemann Hospital was effected, by which the latter institution acquires the property of the former with the proviso, that this property be devoted to the establishment and maintenance of a children's ward in the Hahnemannn Hospital, said ward to be known as the Furness ward.

The reports received from the various hospitals and dispensaries show that they have all attended to a much larger number of patients than during any previous year.

The membership of the various local and county societies as represented in the State organization is devoid of interest. The Allegheny County Society shows the best record of any county association, over eighty per cent. of its members belong to the State Society.

Two local societies have a clean record with the State Society; they are the Hahnemann Club and the Woman's Homœopathic Medical Club of Philadelphia. All the members of these clubs belong to the State Society.

The Anatomical Society of Allegheny County is also well represented, but two of its members not belonging to the State Society.

Respectfully submitted,

CLARENCE BARTLETT, *Chairman.*

HOMŒOPATHIC MEDICAL SOCIETIES IN PENNSYLVANIA.

Name of Society.	When Organized.	When Incorporated.	Meetings.	1886 Annual Meeting.	President.	Secretary.	Number of Members.	Admitted Last year.	Withdrawn Last year.	Died Last year.	Annual Dues	Publications Last year.
					STATE SOCIETY.							
Homœopathic Medical Society of Penn'a.	1866	Not.	Ann.	Philadelphia, September.	David Cowley, M. D., Pittsburgh.	Clarence Bartlett, M. D., Philadelphia. Horace F. Ivins, M. D., Philadelphia.	221	15	. . .	5	$3 00	Transactions.
					COUNTY OR DISTRICT SOCIETIES.							
Hom. Medical Society of County of Phil'a.	1866	Not.	Month 2d Thur	Philadelphia, April.	J. N. Mitchell, M. D., Philadelphia.	H. F. Ivins, M. D., 1319 Arch St., Philadelphia.	166	14	1	3	1 00	Transactions in Hahnemannian Monthly.
Hom. Medical Society of Allegheny Co.	1864	Not.	Month 2d Frid.	Pittsburgh, December.	W. H. Winslow, M. D. Pittsburgh, Pa.	C. H. Hofmann, M. D., 808 Penn Av., Pitts'gh.	48	5	3	1	1 00	
Hom. Medical Society of Chester, Delaware and Montgomery Counties.	1858	Not.	Quar.	October.	Isaac Crowther, M. D., Chester.	Samuel Starr, M. D., Chester.	34	1	1	. . .	1 00	
Lehigh Valley Hom. Medical Society.	1881	Not.	Bi-Month	April.	W. A. Hassler, M. D.. Allentown.	F. J. Slough, M. D., Allentown.	22	. . .	. . .	. . .	2 00	Papers in Journals.
Hom. Medical Society of Northern Penn'a.	1882	Not.	Bi-Month	Pittston, June 22,	Charles Arthur, M. D., Scranton.	T. M. Johnson, M. D., Pittston.	9	. . .	. . .	. . .	1 00	
Hom. Medical Society of Lancaster Co.	1878	Not.	Bi-Month	Lancaster,	O. T. Huebener, M. D., Lancaster.	W. G. Taylor, M. D., Columbia.	11	. . .	. . .	. . .	1 00	
Hom. Medical Society of Crawford County.	1883	Not.	Quar.	Meadville, January.	B. Smith, M. D., Townville.	E. C. Parsons, M. D., Meadville.	19	1	. . .	. . .	1 00	
Beaver County Hom. Medical Society.	1883	Not.	Month 3d Thur	January.	J. S. Boyd, M. D., New Brighton.	W. Raymer, M. D., Beaver Falls.	9	1	. . .	. . .	1 00	
Hom. Medical Society of Western Penn'a.	1881	Not.	Semi-Ann.	August.	P. S. Duff, M. D., Great Belt.	W. W. Wolfe, M. D., 947 Penn Ave., Pittsburgh.	5	. . .	. . .	. . .	50	

Schuylkill Co. Hom. Medical Society.	1883	Not	Quar.	July.	H. G. Wiest, M. D., Schuylkill Haven.	J. S. Kistler, M. D., Shenandoah.	13	2	. . .	. . .	$1 00	
					LOCAL SOCIETIES AND CLUBS.							
Hom. Medical Society of 23d Ward, Phil'a.	1881	Not.	Month	October.	N. T. Jerman, M. D., Holmesburg	W.C.Powell, M. D., 4711 Paul St., Frankford.	15	3	. . .	1		
Philadelphia Clinical Society.	1880	Not.	Bi-Wk Friday.	October.	C. M. Thomas, M. D., Philadelphia.	W. H. Bigler, M. D., 118 N. 12th St., Phil'a.	10	. . .	. . .	. . .	1 00	
Hom. Medical Society of Germantown.	1879	Not.	Month	October.	John Malin, M. D., Germantown.	Harry K. Mansfield, M.D. Germantown.	12	2	1	. . .		
Hahnemannian Med. Society of Reading.	1882	Not.	Month 1st Thu.	Reading, June	W. F. Marks, M. D., Reading.	C. B. Jennings, M.D., 135 S. 8th St., Reading.	13	1	1	. . .	50	
Hahnemann Club of Philadelphia.	1872	Not.	Month	April 10.	B. W. James, M.D., 1719 Green St., Philadelphia	Aug. Korndœrfer, M.D., 648 N. 12th St., Phila.	11	3	. . .	1		Hahnemannian Monthly.
Bœnninghausen Club of Philadelphia.	1877	Not.	Month 2d Wed.	Philadelphia, 1320 Walnut St.	S. M. Trinkle, M. D., Philadelphia.	G. W. Smith, M.D., 1320 Walnut St., Phil'a.	11	. . .	. . .	. . .	6 00	
Philadelphia Medical Club.	1882	Not.	Month 1st Thu.	Philadelphia, December.	W. W. VanBaun, M. D., Philadelphia.	H. T. Wilcox, M.D., 157 N. 15th St., Phil'a.	11	. . .	. . .	. . .		
Woman's Hom. Med. Club of Philadelphia.	1883	Not.	Month 1st Mon	November. 1719 Arch St.	Harriet J. Sartain, M.D., Philadelphia.	Anna M. Marshall, M.D., 1608 Mt. Vernon St.	10	1	. . .	. . .	1 00	
Oxford Social Medical Club of Philadelphia	1886	Not.			James Kemble, M. D., Philadelphia.	H. Knox Stewart, M.D., Philadelphia.	10	. . .	. . .	. . .		
					MISCELLANEOUS.							
Anatomical Society of Allegheny County.	1874	1875	Month last Fri.	Pittsburgh, October.	W. R. Childs, M. D., Pittsburgh.	W. J. Martin, M.D., 1712 Carson St., Pittsburgh.	19	. . .	2	. . .	6 00	
Hom. Pharmaceutical Association of Penn	1881	1882	Ann.	Philadelphia.	A. J. Tafel, Philadelphia.	F. J. Slough, M. D., Allentown.	10	. . .	. . .	. . .		
American Hom. Publishing Society.	1877	1878	Month	Philadelphia, November.	A. R. Thomas, M. D., Philadelphia.	C. Mohr, M. D., 555 N. 16th St., Phil'a.	200	6	. . .	. . .	Stock Com.	

HOMŒOPATHIC HOSPITALS IN PENNSYLVANIA.

Name.	Where Located.	When Incorporated.	When Opened to patients.	Name of Resident Physician or Superintendent.	Number of beds.	Number of Patients treated Last year.	Number cured	Number relieved.	Number not relieved.	Number died.	Source of Income.
Homœopathic Hospital of Philadelphia.	1116 and 1118 Cuthbert St., Philadelphia.	1868	1871	E. R. Snader, M. D., E. L. Oatley, M. D.,	30	483	420	44	12	7	Voluntary Contributions.
Homœopathic Hospital of Pittsburgh.	Second Av., Pittsburgh.	1866	1866	W. D. Slack, M.D., 146 2d Av., Pittsburgh.	200	1026	776	100	40	45	
Children's Homœopathic Hospital of Philadelphia.	914 N. Broad St., Philadelphia.	1877	1877	J. H. Closson, M. D.,	40	105	54	10	.....	4	Voluntary Contributions.
General and Maternity Hospital of the Woman's Homœopathic Association of Pa.	20th St. and Susquehanna Av., Philadelphia.	1882	1884	Mrs. Roswell Weston, 210 S. 41st, St., Phila.	12	101	83	18	.....	.....	Voluntary Contributions.

HOMŒOPATHIC DISPENSARIES IN PENNSYLVANIA.

Name.	Location.	When Incorporated.	When opened to Patients.	Name of Secretary or Executive Officer.	Number of Patients Last year.	Number of Prescriptions.	Cost of Conducting Last year.	Remarks.
Hahnemann Medical College Dispensary.	1105 Filbert Street, Philadelphia.	1874	1848	E. R. Snader, M. D.,	14,554	19,041	$600 00	Volun. Contrib. Deficit paid by Coll. Faculty.
Dispensary of the Hom. Hospital of Pittsburgh.	First Avenue, Pittsburgh.	1866	1866	W. D, Slack, 146 2d Av., Pittsburgh.	6,175	17,924	.....	Supported by Hospital Association.
Children's Hom. Hospital of Philadelphia; Out-door Department.	Carlisle Street, Philadelphia.	1877	1877	J. H. Closson, M. D., 914 N. Broad St., Phil'a.	.....	20,288	.....	Supported by Hospital Association.
Hom. Free Dispensary of Allentown.	34 N. Seventh St., Allentown.	Not.	1877	F. J. Slough, M. D., Allentown.	* 248	1,233	.....	
Hom. Dispensary of Germantown.	Germantown.	Not.	1883 Nov. 15	M. M. Walker, M.D., 12 W. Walnut Ln, G't'n.	527	2,104	175 00	
Dispensary of Women's Hom. Hospital Association.	2136 N. 20th St., Philadelphia.	1882	1884 Mar. 12	Mrs. R. Weston, 210 S. 41st St., Phil'a.	589	2,149	126 61	

*Report for six month.

HOMŒOPATHIC MEDICAL COLLEGE.

Name	When Incorporated.	When opened to Students.	Name and address of Dean.	Length of Yearly Course and time it Commences.	Number of Courses Required.	Number of Students the Past Year.	Number of Graduates Last Commencement.	Number of Alumni.	Number of Faculty.	Number of Professors.	Number of Lecturers and Demonstrators.
Hahnemann Medical College of Philadelphia.	1848	1848	A. R. Thomas, M. D., 1733 Chestnut St., Phila.	Six months. Sept. 26th, 1886	3	161	58	1,637	24	10	14

HOMŒOPATHIC JOURNALS IN PENNSYLVANIA.

Name of Journals.	Name of Publishers.	Name of Editor.	When Established.	How often Published.	Form.	Yearly Number of Pages.	Subscription Price.
Hahnemannian Monthly.	Hahnemann Club of Philadelphia.	P. Dudley, M. D.	1866	Monthly.	Octavo.	768	$3 00
Homœopathic Physician.	E. J. Lee, M. D.	E. J. Lee, M. D. W. M. James, M. D.	1881	Monthly.	Octavo.	576	2 00

LIST OF MEMBERS OF SOCIETIES.

[Names of Presidents in SMALL CAPS. Secretaries in *Italics*]

PHILADELPHIA COUNTY.

Alday, H. B.
Allen, John V.
Allen, Richard C.
Baker, A. E.
Bartlett, Clarence.
Bauer, Rudolph F.
Berkenstock, W. F.
Betts, B. F.
Bigler, Wm. H.
Birch, John P.
Branson, Mary.
Brooks, Chas. M.
Brown, Samuel.
Brown, S. Hastings.
Buchman, Frank.
Castle, D. M.
Christine, G. M.
Conover, T. F.
Cowgill, W. H.
Cresson, C. C.
Davis, E. Everett.
Dudley, Pemberton.
Dunning, T. S.
Egee, J. B. S.
Erwein, F.
Fellger, A.
Fornias, E.
French, H. S.
Gardiner, G. W.
Gardiner, W. H.
Garvin, J. J.
Gause, P. O. B.
Gessler, C. W.
Gilbert, I. B.
Giles, J. W.
Goodno, C. F.
Goodno, W. C.
Gramm, E. M.
Gramm, G. E.
Gramm, T. J.
Griffith, J. J.
Griffith, L. B.
Griffith, S.
Griffith, W. M.
Gross, F. O.
Guernsey, J. C.
Guernsey, W. J.
Gumpert, B. B.
Haines, O. S.
Hamilton, W. C.
Hancock, E. E.
Hancock, J.
Hickman, L. M.
Holcombe, J. R.
Imes, T. C.
Ingersoll, W. K.
Ivins, Horace F.
Jackson, E. B.
Jackson, Lora C.
James, Bushrod. W.
James, H. E.
James, J. E.
Jessup, H. I.
Johnson, Maria N.
Johnston, D. H.
Jones, J. J.
Karsner, D.
Keim, W. H.
Kemble, J.
Kirk, G. J. W.
Kistler, H. E.
Kitchen, J.
Knerr, C. B.
Knerr, L. J.
Kniffen, J. B.
Korndœrfer, A.
Langer, P. J.
Lee, J. K.
Lewis, J. Cresswell.
Lippe, A.
Long, F. Morton.
Macfarlan, D.
Macfarlan, M.
Maguire, W. T.
Mansfield, J. R.
Marshall, Anna M.
Marter, G. W.
Martin, H. N.
McClelland, J. H.
McClure, E. H. Lang.
Middleton, C. S.
Middleton, M. F.
MITCHELL, J. N.
Mohr, C.
Morgan, J. C.
Mount, F. D.
Mullin, W. P.
Neidhard, C.
Neville, W. H. H.
Norton, C. R.
Oatley, E. L.
Parke, G. T.
Parker, G. W.
Peacock, W.
Pettingill, Eliza F.
Pierce, W. A. D.
Posey, L. P.
Powell, W. C.
Powell, W. C., Jr.
Price, F. T.
Quint, S. H.
Raue, C. G.
Reading, J. H.
Reeves, J, M.
Reger, C. Albert.
Rembaugh, A. C.
Ridge, J. T.
Sartain, Harriet J.
Seip, C. L.
Senderling, W. H.
Sharpless, E. S.
Sharkey, W. P.
Shaw, A. R.
Shellenberger, C. N.
Shemp, Park D.
Simmer, E.
Smedley, I. G.
Smith, E. M.
Smith, G. W.
Smith, L. A.
Snader, E. R.
Snyder, D. L.
Somerville, W. H.
Spahr, C. E.
Stambach, H. L.
Stewart, G. W.
Stewart, H. Knox
Still, H.
Straube, Rudolph.
Strong, J. W.
Thatcher, J. W.
Thomas, A. R.
Thomas, C. M.
Thomas, J. Sperry.
Tindall, Van R.
Tomlinson, W. H.
Toothaker, C. E.
Trites, W. P.
Van Baun, W. W.
Van Deusen, E.
Van Lennep, W. B.
Walker, M. M.
Wandell, J.
Weaver, C.
Webb, L. W.
Wilcox, H. T.
Williams, T. C.
Williamson, M. S.
Wrisley, J. A.
Wurtz, John B.
Yearsley, W.
Young, J. H.
Youngman, M. D.
Zerns, W. M.

Chester, Delaware and Montgomery Counties.

Adams, T. L., Berwyn.
Brooks, C. M., Philadelphia.
Crowther, I., Chester.
Hamer, J. H., Collegeville.
Hawley, L. B., Phœnixville.
Hoopes, L., Downingtown.
Johnson, I. D., Kennett Square.
Jones, J. E., West Chester.
Long, S., New Brunswick, N. J.
Maddux, D. P., Chester.
Mercer, R. P., Chester.
Mullin, S., West Chester.
Parker, T. E., Parkersville.
Perkins, C. W., Chester.
Pratt, Trimble, Media.
Rossiter, F. B., Pottstown.
Starr, S., Chester.
Thatcher, J. W., Philadelphia.
Tomlinson, W. H., Germantown.
Urie, W. T., Chester.
Way, J. H., West Chester.
Williams, A., Phœnixville.
Wood, J. B., West Chester.

Allegheny County.

Anderson, E. O., Braddock.
Bingaman, C. F., Pittsburgh.
Borland, W. C., Pittsburgh.
Burgher, J. C., Pittsburgh.
Chantler, I. B., Sewickley.
Chapman, M. J., Pittsburgh.
Childs, W. R., Pittsburgh.
Cooper, J., Allegheny.
Cooper, J. F., Allegheny.
Cowley, D., Pittsburgh.
Crawford, J. S., Greensburg.
Dean, E. W., Braddock.
Dinsmore, S. W. S., Sharpsburg.
Edmundson, W. F., Pittsburgh.
Fleming, R. K., Pittsburgh.
Fulton, H. W., Pittsburgh.
Gangloff, C. H., Pittsburgh.
Grimes, T. H., Sewickley.
Herron, C. D., Pittsburgh.
Hofmann, C. H., Pittsburgh.
Hofmann, H. H., Pittsburgh.
Horner, J. R., Allegheny.
Kerns, W. H. H., McKeesport.
King, W. D., Pittsburgh.
McClelland, J. B., Pittsburgh.
McClelland, J. H., Pittsburgh.
McClelland, R. W., Pittsburgh.
McIntire, R. L., Allegheny.
Martin, W. J., Pittsburgh.
Miller, Z. T., Pittsburgh.
Pitcairn, R. V., Allegheny.
Ramage, R. H., Mansfield Valley.
Rankin, J. S., Pittsburgh.
Ranson, W. E.,
Rinehart, C. C., Pittsburgh.
Roberts, J. F.
Robson, J. W., Pittsburgh.
Rousseau, L. G., Pittsburgh.
Seip, C. P., Pittsburgh.
Shannon, O. R., Allegheny.
Shannon, S. F., Sewickley.
Smith, Mary E., Allegheny.
Starr, Pearl, Robella.
Thompson, J. H., Allegheny.
Willard, L. H., Allegheny.
Winslow, W. H., Pittsburgh.

Lehigh Valley.

Becker, J. G., Bethlehem.
Bunting, T. C., Mauch Chunk.
Detwiller, H., Easton.
Detwiller, J. J., Easton.
Detwiller, J. W., Bethlehem.
Detwiller, W.
Doolittle, E. D., Easton.
Fetherolf, J. A.
Hassler, W. A., Allentown.
Helfrich, C., Fogelsville.
Helfrich, J. H., Allentown.
Heller, H. D., Allentown.
Holben, M. J., Slatington.
Jacobson, E. H., Bethlehem.
Kirby, R. B., Mauch Chunk.
Kistler, A. L.
Slough, F. J., Allentown.
Slough, W. C. J., Emaus.
Yoder, D., Catasauqua.

Northern Pennsylvania.

Arthur, Charles, Scranton.
Brewster, F. D., Tunkhannock.
Bullard, J. A., Wilkes-Barre.
Coe, Sarah J., Wilkes-Barre.
Cooledge, J. W., Carbondale.
Croskey, Harry, Wilkes-Barre.
Dunnell, H. N., Scranton.
Gardner, A. P., Dunnings.
Johnson, T. M., West Pittston.
Ross, S. C. Scranton.

Crawford County.

Benedict, C. W., (Assoc.).
Dunn, J. L., Titusville.
Frazier, J. B., Conneautville.
Heath, L. R., Spartansburg.
Mitchell, Eltha B. (Assoc.).
Morrow, J. O., Evansburg.
Parsons, Anson, Springboro.
Parsons, E. C., Meadville.
Phillips, J. R., Corry.
Pond, J. N., Meadville.
Quinby, E. C., Titusville.
Rose, Susan F., Meadville.
Sellew, S. W., Oil City.
Smith, Byron, Townville.
Smith, E. B., Union City.
Stoneroad, J. D., Meadville.
Waggoner, G. W., Linesville.
Wilmot, E. P., Franklin.

Schuylkill County.

Boyer, F. W., Pottsville.
Dreher, C. B., Tamaqua.
Dreher, Geo.
Haeseler, C., Pottsville.
Kistler, J. S., Shenandoah.
Kistler, Wm., Minersville.
Klock, H. A., Mahanoy City.
Sandal, J. H., Girardville.
Snyder, L. A., Ashland.
Steekel, E. K.
Straup, W. D., Shenandoah.
Swalm, T. W., Pottsville.
Wiest, H. G., Schuylkill Haven.

Beaver County.

Boyd, G. S., Beaver Falls.
Boyd, J. S., New Brighton.
Liscomb, P. D., Beaver Falls.
Nippert, G. N., New Brighton.
Raymer, William, Beaver Falls.
Smith, G. H.
Thompson, J. G., New Brighton.

Western Pennsylvania.

Barnaby, A. M., Red Bank Furnace.
Cleeland, J. S., Freeport.
Duff, P. S., Great Belt.
Leake, E. N., Butler.
Wolfe, W. W., Pittsburgh.

Twenty-third Ward, Philadelphia.

Allen, J. V., Frankford.
Allen, R. C., Frankford.
Byer, J. B.
Cornelius, R. W. B., Holmesburg.
Jerman, N. T., Holmesburg.
Heritage, A. C.,
Humphries, E., Somerton.
Lewis, J. C., Frankford.
May, N., Holmesburg.
Powell, W. C., Frankford.
Pratt, H. C., White Hall.
Reading, H. R., Somerton.
Reynolds, H., Bridesburg.
Umstead, D. B., Tacony.
Van Artsdalen, C., Ashbourne.
Weaver, C., Fox Chase.
Weaver, W. P., Bristol.

Hahnemannian of Reading.

Dreibelbis, S. L.
Grosscup, J. G.
Haman, W. A.
Jennings, C. B.
Kline, D. C.
Knerr, L. J.
Krebs, R. F.
Marks, W. F.
Pachali, Theo.
Rittenhouse, S. R.
Rittenhouse, J. S.
Schmucker, E. Z.
Schmucker, F. R.

Germantown.

Ivins, H. F.
Karsner, D.
Malin, John.
Malin, W. H.
Mansfield, H. K.
Mansfield, J. R.
Mullin, W. P.
Rogers, W. T.
Tomlinson, W. H.
Trites, W. B.
Titman, G. W.
Van Artsdalen, C.
Walker, M. M.

Philadelphia Clinical Society.

Bigler, W. H.
Goodno, C. F.
Goodno, W. C.
Ingersoll, W. K.
Knerr, C. B.
Mitchell, J. N.
Mohr, C.
Norton, C. R.
Thomas, C. M.
Trites, W. B.

Philadelphia Medical Club.

Bartlett, C.
Gause, P. O. B.
Gramm, E. M.
Haines, O. S.
Ivins, H. F.
Maguire, W. T.
Mercer, E. G.,
Smedley, I. G.
Van Baun, W. W.
Van Deusen, E.
Van Lennep, W. B.
Wade, J. K.
Wilcox, H. T.

Hahnemann Club.

Betts, B. F.
Dudley, P.
Dunning, T. S.
Ivins, H. F.
James, B. W.
James, J. E.
Korndœrfer, A.
Middleton, C. S.
Neville, W. H. H.
Smedley, I. G.
Walker, M. M.

Bœnninghausen Club.

Buchman, F.
Dunning, T. S.
Hancock, J.
Macfarlan, D.
Martin, H. N. (Hon.)
Parke, G. T.
Parker, G. W.
Raue, C. G. (Hon.)
Smiley, L. F.
Smith, G. W.
Trinkle, S. M.
Zerns, W. M.

Allegheny County Anatomical.

Bingaman, C. F.
Burgher, J. C.
Chapman, M. J.
Childs, W. R.
Cooper, John.
Cooper, J. F.
Edmundson, W. F.
Hofmann, C. H.
King, W. D.
Martin, W. J.
McClelland, J. B.
McClelland, J. H.
McClelland, R. W.
Rinehart, C. C.
Robson, J. W.
Shannon, S. F.
Thompson, J. H.
Willard. L. H.
Wilson, C. A.

Oxford Social Medical Club.

Kemble, James.
McGill, Edw.
Gilbert, I. B.
Cowgill, W. H.
Holcomb, J. R.
Webb, L. W.
Layman, A.
Owens, R.
Toothacker, C. E.
Stewart, H. Knox.

Woman's Homœopathic Medical Club.

Branson, Mary.
Coe, Sarah J.
French, Harriet S.
Gooding, Gertrude.
Jackson, Lora C.
Marshall, Anna M.
McClure, Eliza H. Lang.
Pettingill, Eliza, F.
Sartain, Harriet J.
Schreiner, Emma T.
Van Deusen, Josephine.

THE BOARD OF CENSORS, during the sessions, reported favorably upon the following applications for membership, and the applicants were accordingly elected:

TINDALL, VAN R., Philadelphia,	Hom. Medical College of Penn., 1864.
BONNET, GUSTAV E., Philadelphia,	Hahn. Medical College of Phila., 1886.
GRIMES, THOS. H., Sewickley,	Bellevue Hospital Medical College, 1876.
THOMPSON, JAMES H., Pittsburgh,	Hahn. Medical College of Chicago, 1886.
GUNDLACH, FRANK C., Allegheny,	Cleveland Hom. Hospital College, 1885.
INGERSOLL, W. K., Philadelphia,	New York Hom. College, 1879.
READING, L. W., Hatboro,	Hahn. Medical College of Phila., 1880.
VAN DEUSEN, EDWIN, Philadelphia,	University of Pennsylvania, 1880.
GERHART, JOS. M., Philadelphia,	Hahn. Medical College of Phila., 1868.
MARKS, W. F., Reading,	" " " " 1869.
BULICK, T. M., Altoona,	" " " " 1882.
MADDUX, D. P., Chester,	" " " " 1883.
DIETZ, W. G., Hazleton,	" " " " 1875.
POSEY, L. P., Philadelphia,	" " " " 1883.
CLOSSON, JAMES H., Philadelphia,	" " " " 1886.
OATLEY, E. L., Philadelphia,	" " " " 1886.
GRIFFITH, J. J., Philadelphia,	Hom. Medical College of Pa., 1856.
BIER, PETER A., Pittsburgh,	Pulte Medical College, 1878.
SEIBERT, W. A., Easton,	Boston Universal School of Medicine, 1885.
WILSON, C. A., Allegheny,	Cleveland Homœopathic Hos. Coll., 1883.
REEVES, JOS. M., Philadelphia,	Hahnemann Medical Coll. of Phila., 1877.

THE REPORT OF THE BUREAU OF MATERIA MEDICA

The following papers were presented through Dr. Edward Cranch, of Erie, chairman:

Differences between Metallic Gold and Its Two Salts, the Muriate and the Sulphate, by E. Fornias, M. D., Philadelphia.

Belladonna, Borax and Agaricus, by E. Cranch, M. D., Erie.

These papers were accepted and referred to the Committee on Publication.

DIFFERENCES BETWEEN METALLIC GOLD AND ITS TWO SALTS, THE MURIATE AND THE SULPHATE.

BY EDUARDO FORNIAS, M. D., PHILADELPHIA.

Some forty years ago Dr. Molin, of Paris, pointed out several valuable differences existing between *metallic gold* and its salts, the *muriate* and the *sulphate*, and since his work came to my

notice I have employed these drugs, successfully guided by some of his observations.

He found that in *Aurum foliatum* and *muriaticum*, *burning* is a predominant symptom, while in *Aurum sulphuricum* the *stitching* prevails; that the duration of action in the three preparations is more or less the same (40 and even 50 days), and that the use of one of them does not interfere with the action of the others.

Dr. Molin employed them alternately and for a long time *in mercurial*, *syphilitic* and *uterine affections*, as well as in *gutta rosacea*, with good results. I have verified his assertions in the two former troubles.

The drugs which seem to diminish the action of the *gold preparation* are:

For *Aurum fol.*—Bell., Cocc., Merc. sol. and Solan. nig.

For *Aurum mur.*—Bell., Cinnab. and Cocc.

For *Aurum sulph.*—China, Graph. and Stram.

Cold, walking and riding in a carriage seem to aggravate the symptoms of *Aurum fol.* Conversation and music lessen them.

The aggravation for *Aurum mur.* is produced by cold, heat, coffee, tea and wine. Music and riding in a carriage decrease the sufferings.

In *Aurum sulph.*, cold, walking, riding in a carriage or on horseback, noise, coffee and tea, increase the sufferings, which are only lessened by rest in bed.

Special Analysis.

MIND.—*Aur. fol.* has impatience, anger and religious exaltation, which are not found in the others. Only *Aur. mur.* has alternation of mirth and sadness.

HEAD.—*Aur. fol.* has an eruption of white vesicles on the scalp; *Aur. sulph.*, burning and itching in the head, but no eruption. Only *Aur. fol.* has *hemicrania* with nausea, pain in the stomach, and even vomiting. In *Aur. mur.* and *Aur. sulph.*, we find the swaying of the head, which does not occur in *Aur. fol.* Only *Aur. sulph.* produces *falling of the hair.*

EYES.—*Aur. fol.* is the only one that has beating and stitches in the internal angles of the eyes, and also the only preparation of gold which has proved beneficial in *lachrymal abscess.* Lachrymation occurs in *Aur. fol.* and *Aur. mur.*, but not in *Aur. sulph.*, which

only exhibits pulsation in the eyes and a great sensibility to light.

NOSE.—In *Aur. fol.* and *Aur. mur.* the *coryza* is fluent (thick and offensive in the muriate). In *Aur. sulph.*, on the contrary, it is dry, and it is the only one that has small *furfuraceous herpes* on the nose.

MOUTH.—Paleness of the tongue and gums is only found in *Aur. sulph.*, which has proved to be the most useful in *chlorosis*. It is likewise the sole preparation of gold, whose symptoms point to *prosopalgia*.

FACE.—The symptoms of the face are nearly the same in *Aur. fol.* and *Aur. sulph.*, but null in *Aur. mur.*

THROAT.—The swelling of the cervical glands given in *Aur. fol.* has been verified by Dr. Molin only in *Aur. mur.*

STOMACH.—The eructations are watery in *Aur. fol.*, putrid in *Aur. mur.*, and have the taste of food in *Aur. sulph.* *Aur. fol.* and *Aur. sulph* have frequent hiccough, while *Aur. mur.* has continuous yawning, a symptom not found in the two former remedies.

ABDOMEN.—*Aur. fol.* is the only one which has heat, painful dryness, a feeling of scraping in the groins and weight in the pubes. *Aur. mur.*, redness of the umbilicus with heat, itching and smarting, as well as an eruption of red pimples above the pubes. *Aur. sulph.*, a sensation as if a ball were rolling in the abdomen, and lacerating pains.

STOOLS.—*Aur. fol.* has *diarrhœa* during the day or at night, with stools sometimes green, sometimes gray. *Aur. mur.*, *diarrhœa*, principally at night, with whitish-gray stools. *Aur. sulph.*, constipation; *Aur. fol.* and *Aur. mur.*, *hæmorrhoids* and flowing of blood at stool.

URINE.—*Painful micturition* and diminished urine are found in *Aur. fol.* and *Aur. mur.* *Incontinence* of urine at night, belongs to *Aur. sulph.* (Dr. Molin reports the case of a young lady, 22 years of age, of marked lymphatic temperament, suffering from incontinence and complaining at the same time of glandular swellings, chronic inflammation of the nose, with redness, tumefaction, sensibility to touch and the constant formation of crusts in the nostrils, who, after many allopathic and homœopathic remedies, was radically cured by *Aur. sulph.* He was led to its use by the combined state of the nose and bladder.)

SEXUAL ORGANS:—In *Aur. fol.*, the *leucorrhœa* is thick and white. In *Aur. mur.* and *Aur. sulph.*, it is yellow and flows principally in the morning. It is clear in the former, and thick in the latter. *Aur. fol.* produces *delayed menstruation*, which does not happen with *Aur. mur.* and only irregularly with *Aur. sulph.* *Aur. mur.* is the only one that produces large red pimples on the labia majora a few days before menstruation. The *painful tumefaction of the testicles* has only been observed under *Aur. mur.* and *Aur. sulph.* *Too short erections, with a strong desire for coitus and inability to satisfy it*, belong to *Aur. sulph.*

LARYNX.—The cough in *Aur. fol.* is dry, with various gradations (little or no expectoration). In *Aur. mur.*, it is moist, with yellow, thick, abundant expectoration, sometimes blood-streaked. In *Aur. sulph.* the same character of cough and the same yellow expectoration, but occasionally some pure blood. The voice is somewhat husky in *Aur. mur.* (also in *Aur. fol.*) but very much so in *Aur. sulph.* (Note, Dr. Molin thinks that many symptoms ascribed to *Aur. fol.*, belong really to *Aur. mur.*

CHEST.—In *Aur. fol.*, the chest and heart symptoms are very numerous and well marked. It is the only one that has palpitation while lying on the back, (or when riding or walking). In *Aur. mur.* and *Aur. sulph.* there are nightly spells of suffocation, which do not occur in *Aur. fol.* (?)

TRUNK.—*Aur. fol.* and *Aur. sulph.* have painful parotids and a kind of *torticollis*. *Aur. sulph.* has *swelling* and *sensitiveness of the mammæ*, to touch, as well as *fissured nipples*, with stitching, smarting and itching. In this salt of gold are also found many interesting symptoms referable to the spine.

EXTREMITIES.—The symptoms of the upper and lower extremities not only prove the usefulness of these three preparations in *mercurial affections* and *gout*, but they suggest their applicability *rheumatic* troubles. (Dr. Molin has used them with good results in *chronic rheumatism*). This is particularly the case with *Aur. mur.*, which presents most markedly the symptoms of the lower extremities. Two interesting symptoms belonging to *Aur. sulph.*, are the staggering with a kind of uncertainty in the lower limbs and a feeling of numbness in the feet. (Dr. Molin has found it useful in some cases of *myelitis*.)

It is also worth remarking here how evident in *Aur sulph*, is the double action of its two components.

BELLADONNA, AGARICUS AND BORAX.

BY EDWARD CRANCH, M. D., ERIE.

The following study of Belladonna, in association with Agaricus and Borax, was begun in consequence of two independent remarks, one by Alphonse Teste in his Materia Medica, the other by W. J. Blakely, a former president of this Society, but now deceased. Teste not only places Agaricus next to Belladonna in his Belladonna group, but states in a foot-note to Agaricus that once, when he was called on to relieve a case of convulsions that he had often before controlled by means of Belladonna, he now, finding his Belladonna vial gone, gave Agaricus instead, and, he says, the result was the same.

Blakely once said to me in conversation that he considered Borax many times called for, when a first glance might suggest Belladonna.

It, therefore, occurs to me now to examine the pictures of these drugs, and discover the family resemblances, if any, so that hereafter we may distinguish the members of the family better, by knowing what little peculiarities to look out for. Polypharmacy would suggest giving all at once when in doubt, but that would be like a combination photograph, blurred and unsatisfactory, not the card by which to identify the wily criminal, disease.

In the mental symptoms, the violence and rage that are prominent under Belladonna and Agaricus, are moderate or absent under Borax. In all three, these symptoms are fitful, and alternate rapidly with other moods, and in all three, the states of exaltation, with increased activity and strength, are followed by states of depression, lassitude, idleness, and so forth. Under Belladonna, the stage of active delirium is most marked; under Agaricus, the stage of silliness; under Borax, the stage of torpor, yet in the secondary stages of all, flashes of the maniacal delirium, the crazy silliness, and the apprehensive startings recur with more or less frequency, and

always suddenly. The Belladonna patient in fever, forgets all surroundings except as they oppose him directly, and he boldly rises from bed; the Agaricus patient will watch his chance and slowly sneak his feet out before attempting to rise; the Borax patient is startled by every noise and shock, and especially by any downward motion, but the emotion excited is fear, and not rage, as in Belladonna, or timid ill-humor, as in Agaricus.

The Belladonna child starts with the whole body; the Agaricus child has tremors of an eye-lid or other simple part of the muscular system; the Borax child dreads always a downward motion, and expresses fear and solicitude without any specially characteristic muscular action, beyond the usual facial changes in states of fear.

The profound coma and stupor of Belladonna are not found in the other two drugs under consideration.

In the symptoms of the head, they are all sufficiently contrasted by the following characteristics:

The Belladonna subject dreads the slightest jar, and the scalp is extremely sensitive, the pulsation marked; the others have none of this. The Agaricus subject complains chiefly of a weary brain, as after sexual and other excesses, with tendency of the head to fall backward, sometimes with an icy feeling, or a pricking as of needles, like Kali carb., with sensitiveness only in spots, like Kali bichromicum. The headache of Borax is not peculiar, but the hair often shows a tendency to become knotted and adherent. Upon the eyes, the action of the three drugs is strikingly similar, but in Belladonna, the sparkling look, in Agaricus the twitching, in Borax the redness and inversion of the lids will serve to contrast them.

The ears of Belladonna pain more than they itch, the ears of Agaricus itch more than they pain, the ears of Borax resemble the others in their inflammatory discharges, hardness of hearing, stitches, crackling, stopped sensations and roaring noises, but have no itching nor over-sensitiveness to sound, as the others have. The facial redness, heat, swelling and pallor are alike in all, but in Belladonna they change more rapidly and attain a greater heat.

In the mouth and throat, Belladonna has no actual lesions of the lining, as Borax has, with their elongated form, yellow pus and offensive odor, but the spasmodic element in Belladonna is fore-

most, even imitating that of hydrophobia, but most usually with dryness. Agaricus has neither actual lesion nor marked swelling, but a copious saliva of all sorts of bad taste, while the nose seems as if stopped with cotton, and solid balls of phlegm are hawked easily from the throat, as in the commencement of certain colds. In Belladonna colds, the throat suffers most, in Borax colds the nose ulcerates inside and out, in Agaricus colds, it feels as if stopped by cotton wool. The mucous membrane of the Belladonna case is mostly hot and dry; of the Borax case, moist, eroded and offensive; that of Agaricus feels astringed and tastes badly. The stomach of Belladonna is affected with few but violent symptoms, mostly referable to the nervous system, strong cravings and sudden vomitings, violent pain as of neuralgia; the Borax stomach is sore as if eroded, and desires food, but chewing, deglutition and the mechanical pressure of the food in the stomach are all painful; the Agaricus stomach feels as if it had been through a heavy debauch, and loathes food and drink. The abdominal and bowel symptoms of Belladonna are strongly marked and well known; the others have but faint disturbances, of little distinctive value. The urinary symptoms in all are striking and important, besides being of close similarity, but the sediment with Belladonna is oftener red, that of Agaricus oftener white, that of Borax has not been observed, but the urine is hot and pungent. All affect the sexual system, and are extremely useful therein, for effects of over-use, for hemorrhages and profuse discharges of all kinds, but especially when hot and offensive. Belladonna controls hemorrhages of this character; Borax relieves profuse, hot, *fluor albus*, and has removed sterility; Agaricus is powerful in the exhaustion of head and limbs that follows excess, comparing well with Staphisagria, Carbo vegetabilis and China. The cough of all is violent, with slight expectoration; Belladonna has the larynx very painful and hoarse; Borax scarcely affects the larynx, but has a mouldy taste and smell with the slight expectoration; Agaricus has much sneezing, with violent cough. All three remedies increase the flow of milk, and have tightness of chest, most markedly constrictive with Agaricus, and most painful with Borax.

The heart has been studied most under Belladonna. I think careful proving would discover nearly equal disturbances of the

heart and pulse under the other two. Muscular symptoms in Belladonna and Agaricus are referable to the excitement of the cerebellum and medulla spinalis, the former mostly by Belladonna, the latter by Agaricus. Borax leaves the nervous system quiet, except for a state of apprehensiveness and general susceptibility to impressions. The muscles are at rest unless moved by the patient.

The general movement of the Belladonna subject is that of readiness to start into spasm, that of Agaricus of prostration and tremor, that of Borax is to keep quiet for fear of hurt.

The skin of Belladonna looks excessively hot and feels so even at a long distance; that of Agaricus only looks red, if at all, in small spots that burn as if reacting from frost bite; the skin of Borax looks hot, but does not feel so except on touching it firmly.

The action of Belladonna on the skin is severe and decidedly erysipelatous, followed by pustules, scabs, and desquamation of epidermis. Agaricus causes various degrees of fine pricking and itching. Borax displays a profound disturbance of nutrition, shown in its unhealthy, easily festering skin, almost like its action on the mucous membrane.

Belladonna subjects sleep profoundly, but with frequent violent starts, sometimes serving to prevent actual sleep, however sleepy. The smaller twitchings and shocks of Agaricus act in the same manner, but with far less violence and prominence among the other symptoms, which in Belladonna become characteristic.

The sleep of Borax is disturbed as by fright, but no true convulsive movements have been observed. The fever of Belladonna is most marked, that of the others scarcely deserves notice, except that they present the *appearance* of fever while the rise of temperature and pulse is slight. The aggravations of Belladonna and Borax are mostly after 4 P. M.; those of Agaricus are more dependent on circumstances than on time.

To sum up, it is easy to see a resemblance, where one is looked for; nevertheless, these three drugs may well be considered together on some occasions, as in feverish children, with sore throats, nervousness, delirium, dread of being touched, fear of convulsions, erysipelas, inflammation of eyes and ears, pains in the stomach, profuse discharges and disturbed sleep.

Perhaps, among the three, the Borax can be soonest decided upon, to be taken or dropped; between the two others, Belladonna and Agaricus, the degree of action must often alone decide, that of Belladonna being the most powerful and acute, that of Agaricus, milder and more localized; that of Borax most mild, but affecting more changes in actual structure, approaching an action like the antipsorics of Hahnemann.

Belladonna is ready to start, Agaricus is ready to rest, Borax is resting and fears to be disturbed.

In conclusion, I would like to record my conviction that the first essential of a useful knowledge of *materia medica*, and of repertories, is a frequent, exact and comparative study of individual drugs; that every physician should, for mere study, construct and revise and write out his own materia medica, not with a view to publication, but solely with a view to familiarize himself with his tools and keep them ready in his mind for verification and use. Let him write frequent monographs on drugs, with full comparisons, and he will find full and ample reward, in greater ease and certainty of practice. No other means serves so well to digest the material so rapidly ingested during the college course. No other means will make him so surely appreciate a good library and many journals, or give him such confidence and, therefore, pride in his profession.

THE REPORT OF THE BUREAU OF OPHTHALMOLOGY, OTOLOGY AND LARYNGOLOGY

Was next received. The Chairman, Dr. W. H. Winslow, of Pittsburgh, was absent, so the report was presented by Dr. Horace F. Ivins. The following papers were read and referred for publication.

Hydrastis Canadensis in Diseases of the Ear, by W. H. Bigler, M.D.

Paralysis of the Iris, by W. H. Winslow, M. D.

Some Notes on Hay Fever, by Horace F. Ivins, M. D.

HYDRASTIS CANADENSIS IN AFFECTIONS OF THE EAR.

W. H. BIGLER, M. D., PHILADELPHIA.

We may safely say that the majority of aural diseases presenting themselves for treatment are such as depend upon an altered condition of the mucous membrane lining either the cavity of the middle ear, the Eustachian tube, or the pharyngeal and nasal cavities. The integrity of the membrane lining all of these is necessary to the perfect performance of the functions of the ear.

It is natural, therefore, to look for remedies for diseases of the ear among those that have been proved to be capable of producing decided effects in these regions. One of the most important of these is the *Hydrastis Canadensis.*

It seems to have a peculiar affinity for mucous membranes and of its action upon this tissue, Hull says: The natural secretion is at first increased, then it becomes abnormal in quantity and quality. At first clear, white, and tenacious, it becomes yellow, very thick, green and even bloody, and nearly always tenacious, so that the discharge may be drawn out in strings as with Kali bich. This stimulant action may go on to cause erosion and ulceration.

In accordance with this, we find recorded the following symptoms of nose and throat, which will be of use to us in defining its sphere in aural diseases according to their concomitants:

Sharp, raw, excoriating feeling in both nares, with constant inclination to blow the nose, with hoarseness.

Fluent coryza, followed by thick catarrhal discharge. Constant discharge of thick, white mucus, with frontal headache.

Secretion so profuse as to be removed in long tenacious shreds or pieces.

Ozæna, with ulceration, bloody or mixed purulent discharge.

Stuffed up, smarting sensation in posterior nares, with discharge of thin, clear mucus.

Hawking up of tenacious, yellow or white, mucus, with rawness of the fauces.

Sticky mucus in the fauces, with bad taste.

We see now the progressive stages of the affection of the membrane as it creeps along by continuity of tissue from the nose up into the naso-pharynx and pharynx, and are not, therefore, surprised to find the following symptoms of the ear.

Roaring in the ears like cog-wheels or the drumming of a partridge. This symptom is not referable to debility, but, as its place in the proving shows, to an extension of the disease of the mucous membrane to the mouth of the Eustachian tube. As it progresses still further through the tube into the cavity of the middle ear, we have the true tinnitus aurium. We have in these symptoms a complete picture of a subacute catarrhal inflammation of the middle ear, with its almost invariable antecedents. According to our experience, it is an exceedingly rare occurrence for this disease to be found except as an extension from the nose or throat or from both.

We have, then, in Hydrastis a true similar to a class of aural troubles that are of very frequent occurrence. and which, when allowed to go on untreated, are sure to result in impaired hearing and eventually in total deafness.

According to the above picture, and its practical verification, this drug will be indicated when with the symptoms of tinnitus and hardness of hearing, we have an involvement of the naso-pharygeal space, with the characteristic tenacious secretion. The patient will complain of feeling something in his throat that it is at times impossible for him to detach, either by hawking or by swallowing. An examination of the throat will show a streak of tough, white, tenacious mucus, so closely adherent to the posterior pharyngeal wall, that it is difficult to remove it even with the aid of a cotton armed probe. On examining the ear, the drum membrane, while still retaining most of its translucency, shows by the real position of the pyramid of light that it is somewhat depressed. The auscultation tube used in connection with the Eustachian catheter enables us to diagnose a moist catarrh of the tube, corresponding, no doubt, in general characteristics to that found in the pharynx. In such a case, Hydrastis, from the 3^x upward, will be sure to benefit much, if not to cure completely. A gargle of the tincture in water, or an application of the same by the physician will be found to assist the internal use of the remedy. This use of

Hydrastis is no doubt familiar to many if not to all of us, but there is another, to which I have never seen reference made, but which has proved so satisfactory in a number of my own cases, that I offer its mention as the only justification of the present paper.

From our knowledge of the natural course of disease, we are warranted in supposing that, with the provings of the drug continued far enough, we would find another complex of symptoms resulting, even more difficult to relieve.

We would find, subjectively, the deafness increased, the tinnitus more constant and distressing, while objectively, the pharynx wall would present a tense, dry, glazed appearance, the drum membrane would be opaque and tightly pushed inward over the ossicles of the tympanum, the prominent points of which would have become strikingly apparent. The cone of light would have changed its shape and position, and perhaps would have disappeared.

The patient would complain of hawking up at times, with much effort, bits of greenish mucus, as tough as gristle. The auscultation tube would no longer bring to our ear moist râles, but a fine dry whistle, indicating a dry sclerosed condition of the Eustachian tube, undoubtedly similar to that found in the pharynx.

This condition we find realized in the chronic catarrh of the middle ear, so insidious in its approach, so disastrous in its effects upon the hearing, and so little amenable to the usual treatment. Here, where so many other remedies fail, I have found Hydrastis more reliable. The manner of its use differs from that recommended for the moist variety first spoken of. To that, by Hydrastis is primarily homœopathic, and the curative dose will be relatively high; to the condition now referred to, it is secondarily homœopathic, and the curative dose must be low.

The preparation and dose that I now use is the so-called *Sulphate of Hydrastin*, either pure or the 1^x, in water, in frequently repeated doses. The tincture of Hydrastis and the Hydrastin have both failed to give me the satisfaction that I have desired from the use of this preparation in these doses. Under this remedy, the patient gradually finds less difficulty in detaching the tough mucus, which becomes lighter in color and softer in consistency; the posterior pharyngeal wall loses its dry glazed appearance, and the moist râles again are heard; the drum membrane becomes more

movable, and in consequence of these changes, the hearing improves and the tinnitus is less persistent and aggravating.

The amount of improvement that we may hope to obtain will depend upon the length of time that the disease has existed and the consequent changes that have taken place in the tissues.

We will find that there is a decided difference in patients in their susceptibility to this drug, a difference that can only be arrived at by experiment. A dose that in the one will produce a real blenorrhœa nasi will in another cause only a dryness, and *vice versa*, confirming the fact that meets us on every side, that the terms "high" and "low," when applied to the dose in general, must be regarded as entirely relative.

In very old cases, these have so degenerated that a cure is absolutely impossible and relief scarcely to be expected, but let no case of chronic catarrh of the middle ear be given up until a fair trial has been made of the Sulphate of Hydrastin.

PARALYSIS OF THE IRIS.

BY W. H. WINSLOW, M. D., PITTSBURGH, PA.

In my first series of twenty-five operations for cataract, which I reported in the *Hahnemannian Monthly* this year, a unique case occurred to which I call attention.

The usual incision had been made, and, as I cut the corneal bridge above, the lens shot out and the upper segment of the iris disappeared from view. I did not see the knife cut the iris, and I could not find any fragment of it anywhere. The upper margin of the iris was drawn back so completely behind the arcus senilis and wound that no kind of illumination would show its edges.

The pupil was a clear vertical ellipse, and I concluded that the lens in its exit had paralyzed the upper half of the iris, but I was astonished at not being able to discover its free border, and it seemed unaccountable.

We know that injury or paralysis of the pupillary fibers of the motor oculi will cause a dilatation of the pupil, but the iris forms a narrow rim round the large black lumen and beneath and just inside of the corneal periphery. There is rarely any difficulty in seeing it with the naked eye by proper illumination.

There is little in ophthalmic literature upon this subject. Dr. Haynes Walton, in his work upon the eye, page 435, has a paragraph upon "The apparent loss of a part of the iris, or the whole of it, after a blow." He gives in substance from an article by Mr. Solomon: "If the ciliary nerves be divided by wounds, so much of the iris as the nerves supply will collapse and the pupil extend to the cornea. * * * Moreover, dissection has proved that the greater part of the iris may escape an external examination, and yet be found within the eyeball."

From an article by Von Ammon, who gives the details of an examination after death, of an eye in which the major part of the iris was rendered invisible by the concussion from a musket, which was loaded with water instead of lead, and discharged into the mouth by a young soldier who had determined on committing suicide:

"The only visible portion of iris in the right eye was a crescentic fragment towards the external side. The point where this portion disappeared was neither torn nor abruptly folded inwards, but disappeared without its being possible to discern what had become of it; dissection showed that the upper, inner and lower borders of it were pushed back. The lens with its capsule was partly dislocated.

"When the lens and vitreous body were removed under water, the iris slowly returned to its position."

In my case, the ciliary nerves were not injured in the corneo-sclerotic incision made for extraction. The shock to the patient from the pain, and that to the eye by the sudden escape of the lens, as if shot out of a catapult, must have paralyzed the upper ciliary nerve fibers and the superior fibers of the sphincter muscle by over-stretching, and caused the extraordinary and complete recession and consequent invisibility of the superior half of the iris.

If such a result could be always produced in cataract extraction, it would be a vast improvement upon the ragged and mutilating operation of iridectomy, but experience is against squeezing the lens through the pupil on account of the danger of iritis and of prolapse of the iris, but we may occasionally succeed in getting a good result by accident.

SOME NOTES ON HAY FEVER.

BY HORACE F. IVINS, M. D., PHILADELPHIA.

It is not my intention to advance any new theory as to the origin of this very speculative affection; nor do I purpose offering any arguments either to attempt verification or disproval of existing theories. My object is simply to state some points relative to personal experience in the treatment of hay fever patients. That this experience is very different from that of others is to be expected, and I hope that their views may be brought out in the discussion. It is scarcely necessary to add that I have made use of the term "Hay Fever," not because I think it more accurate in its application than are others, but because it is the name most frequently employed.

My first case of hay fever presented itself before I began active practice, and, as usually occurs to beginners, this person had been treated by more than one physician; in this instance, however, homœopathic only.

The subject was a woman with a scrofulous history; but when I began treatment she was in a good physical condition except that in the latter part of June she was very much annoyed by the following train of symptoms: first, sneezing, apparently occasioned by a sensation of fulness, itching and burning in the nostrils; the conjunctivæ became congested; the eyelids itched quite severely, and rubbing gave only unsatisfactory relief. Soon nasal respiration became impaired and was finally abolished. There was a marked flow of acrid tears and of nasal mucus, neither of which caused excoriation but produced a redness of the parts over which they flowed. The head ached considerably, the eyes were sensitive to light, and sleep and appetite were disturbed. Pollen and dust of any kind aggravated these symptoms.

For a number of years it had been customary for this condition to last from five to seven weeks every summer. A dose of Allium cepa^{200x}, three times a day, was begun in the early part of the attack. Inside of forty-eight hours, the remedy had a marked effect in relieving the symptoms, and at no time during that summer were the paroxysms severe; while the duration of the affection was only a little over three weeks.

Both of us being greatly encouraged by the partial success attained in so short a time, it was decided to repeat the trial the next season when the patient began taking the Allium cepa one month before the nasal symptoms had usually made their first appearance. One dose a day constituted the treatment. This was continued until the time for the termination of her seizures was past; no symptoms appeared, further than such a slight nasal catarrh as any one may contract during our changeable summer weather.

The third summer was passed with but a dose of the same remedy once a week. No symptoms of hay fever presented during that season, nor have any since then made their appearance.

The drug has not been used for three or four years. Only a few weeks ago, while out in the country, I met my old patient on a windy day on a dusty road at just such a season as would correspond to the height of her former seizures. She said she was well and expected to remain so.

As far as known either to this person or to myself, no change was made in her surroundings; and no local treatment was employed, neither was the remedy given in any preparation other than the 200^x; Boericke's.

This case made a profound impression upon me, especially as it was the first hay fever case which I had seen during the paroxysms, and the cure, in this instance, seemed so evidently the result of the happy prescription that I give this detailed account of it here. My success thus early achieved has led me to use the Allium cepa in other cases in which the symptoms corresponded, more or less closely, with my first patient's; although I have since used the 30^x potency only. In the cases so prescribed for, relief has always followed. One was cured by the remedy alone, but in the others it has seemed necessary to resort to some mechanical or local measures, as the medicine failed to give more than partial relief. In the *true* hay fever patients the adjuvants used were: the puncture of the swelled portions of the mucous membrane with a narrow knife blade; the use of cocaine or of the galvano-cautery. In the cases which were complicated, aggravated or incited by hypertrophied tissue, adenoid vegetations, or polypi or other tumors, my first effort has been to remove these irritants and obstructions

either by means of the snare, forceps, or galvano-cautery, together with medicines. A number of such cases have presented and have usually been promptly cured by such removal of the exciting cause. One person had been treated for a number of years under the impression, on his part at least, that there was nothing further than a most aggravated condition of hay fever, since he was comparatively comfortable excepting during his season of paroxysms. A large polypus was discovered in each nasal cavity, perhaps not large enough to close the passage completely when the mucous membrane was not under the irritating influences incident to the fever period; but as soon as these conditions prevailed nasal respiration became impossible and for about two months, relief was considered out of the question. The polypi were removed, nothing else was done, and immediate relief followed, all hay fever symptoms disappearing. This is but an aggravated case of a class of which I have seen several.

Adenoid vegetations have produced similar symptoms, the cure following the removal of the hypertrophies; therefore, while medicines will cure many cases, it must always be borne in mind that there is, possibly, some chronic obstruction which is really the cause of the affection, and the former must be removed before the latter can be relieved.

The knife puncture I have abandoned in favor of cocaine or galvano-cautery. A word as to my plan of using these may not be out of the way here. The cocaine is used either in a 2 per cent. or 4 per cent. solution, or better, perhaps, by means of the introduction of cocaine tablets within the nostrils once or twice daily. The drug should not be used when nasal respiration is not actually interfered with. The action of the cocaine, while usually quite transient, is sometimes sufficient to give lasting relief when used in conjunction with the internal remedy. In the use of the galvano-cautery, it has never appeared to me necessary, nor even wholly safe, to destroy large areas of the nasal mucous membrane, as has been advocated by some. I prefer, rather, to make slight antero-posterior incisions into the most enlarged portions, using for this a thin galvano-cautery knife blade. The beneficial effect of this method of cauterization is shown by the inverting of the edges which takes place during the process of healing and the

consequent contraction of the enlargement. It is often necessary, should the nasal obstruction return, to make a second or even a third incision always in the same line, thus avoiding any sloughing of the tissues or a destruction or impairment of the normal functional activity of the parts. Some one or all of these methods of treatment have served to give relief in every case, and in some to result in cure. If the cautery is applied during the height of the attack, it is often quite painful, but not more so, in many cases, than the contact of a probe. It is always advisable to apply cocaine before using the galvano-cautery knife.

After the attack has fairly started it is often very difficult to give more than partial relief, but even that is very grateful to the patient and is highly appreciated.

Although my chief reliance has been placed upon Allium cepa, as an internal remedy, I have had much assistance from others, especially in relieving certain groups of symptoms. *Euphrasia* has served to lighten the attack by controling the profuse excoriating lachrymation with swelling and inflammation of the lid margins, together with burning and itching, causing the patient not only to wink frequently, but to rub the eyes.

Arsenicum is useful when the discharge burns and bites, the burning sensation extending well into the nasal cavities.

Gelsemium often gives relief to the premonitory symptoms, that is to say the fulness in the frontal region, the dryness in the nostrils and the nasal obstruction, when not marked. This remedy is rarely useful unless there be a pain in the back of either head or neck.

Arum triphyllum assists much when we find an acrid, thin discharge with excoriations at the union of the skin and mucous membranes. In one case, it was the only remedy used and has apparently resulted in a cure. The 12^x was the potentcy. No local measures were adopted.

Sanguinaria canadensis often acts well in relieving symptoms which persist after the patient seems nearly well and yet does not entirely recover by the use of other drugs.

Sanguinaria nitrate, by controlling the hypertrophic tissue in the naso-pharyngeal regions, often prevents subsequent attacks, and

Nux vomica has frequently given great relief to the nightly aggravations of dyspnœa.

As ophthalmic adjuncts none give greater relief generally than the daily or bi-daily, instillation into the conjunctional sac of a 1 per cent. or a 2 per cent. solution of hydrochlorate of cocaine, a weak aqueous solution of Boracic acid acts better in others, while cosmoline, vaseline, rose water or warm salt water acts more gratefully in still others. Colored glasses are useful in nearly every case.

DISCUSSION.

Dr. W. H. Malin, of Chestnut Hill, said that as a sufferer from hay fever, he had used Allium cepa, and all the remedies mentioned by Dr. Ivins, with only partial relief. Yesterday, he was suffering intensely, the nose discharged profusely and his eyes, neck and forehead itched intensely. He then took *Aconite0*, four drops, three times a day. To-day, he had no hay fever, the discharge had stopped and the itching had entirely ceased. The symptoms may return, however.

Dr. L. H. Willard, asked Dr. Malin if he had ever tried Aconite before.

Dr. Malin replied that he had not used it before in the way he had tried it yesterday. He had also tried Sticta, Natrum arsenicosum and Silicea, but without any benefit. He had also tried cocaine, which relieved him for half an hour. He had obtained more benefit from the Aconite than from anything else.

Dr. J. H. McClelland said that Dr. Blakely, of Manchester, England, had written a classical work on hay fever. After giving his experience with a number of drugs, the author settles on the arsenical preparations as being the most effective, and of these he prefers the iodide. While it does not cure the disease, it modifies the attacks. Dr. McClelland also observed that he had, himself, used the arsenical preparations and had settled on *Natrum arsenicosum* as being the best of these. He thought that where, however, asthma was a prominent symptom, he obtained the best results from Arsenicum jod.

Dr. Henry Noah Martin remarked that he had used Allium cepa with very excellent results in this disease. Arsenicum jod. had also been a favorite medicine with him. Natrum arsenicosum he had used sometimes. He then proceeded to detail a case which had been to him one of great interest. The case was one in which the asthmatic symptoms predominated. The patient, a young lady, came into his office twenty years ago, suffering from asthma. He then gave her Arsenicum without any result. She then passed into Dr. Richard Gardiner's hands. She has since married. She had never received any benefit from either medicine or change of climate. She recently sent for him again. He found her suffering from a number of asthmatic symptoms with a gastric disturbance. She had a great deal of nausea and indigestion, which she said was always the case when she had asthma. The symptoms then indicated Iris versicolor, so he gave that remedy. It not only relieved the stomach symptoms, but the asthma also. She then had symptoms which indicated Mercurius, so he gave that remedy. That was two years ago and she has had no asthma and hay fever since. In this case, Dr. Martin thought that the mistake was that she had not been treated for the stomach symptoms. He thought that we all make mistakes in not taking into consideration the general symptoms of the patient. He once recommended a lady with hay fever to go to Schooley's Mountain, and there she had so severe an attack that she could not remain, yet he had sent five or six other patients there with benefit.

Dr. Jno. K. Lee said that hay fever was recognized as the approbrium of medicine. As in other diseases, each case requires individualization. He had used Arsenicum jod. in some cases and also Allium cepa. By individualizing our cases, we will meet with better success than we would by the use of adjuncts.

Dr. M. J. Buck had had very good results from Capsicum in the sixth or twelfth trituration. He had not seen this remedy recommended in literature, but he had prescribed it from the well known effects of Capsicum on mucous membranes. In two cases, it relieved inside of ten or twelve days. Dr. Buck agreed with Dr. Lee in the propriety of individualizing our cases, but he also remarked that there are some cases in which it is impossible to individualize.

Dr. W. H. Bigler said that he had obtained great relief of the sneezing in one case by Natrum mur.[6x]

Dr. L. H. Willard referred to Dr. Lee's remark concerning the non-use of palliatives. As for himself, he said that he was only too glad to get a palliative for some of his cases. Our patients are great sufferers. Cocaine gives relief, so he uses it because the distress is so great. He did not think it right to withhold these applications.

Dr. W. H. Malin said that he believed that the disease reproduces itself each day, where one is exposed to dust or pollen. In his own case it is the pollen from the rag-weed that affects him.

Dr. J. K. Lee held that this disease, as well as any other, is susceptible to individualization and successful treatment. If we sit down to study and carefully isolate the symptoms, we will obtain good results. He was sorry to hear members imply that our law is not of universal application. If it is not applicable to hay fever, it is not to other diseases. Dr. Lee took the ground that it was applicable to all diseases. These adjuvants may be useful as palliatives, but they ought never to supersede the treatment by the indicated remedy.

Dr. Willard would not have it understood that he habitually resorts to palliatives. He thought, however, that hay fever, being a local disease, its symptoms may disappear very suddenly. He also suggested that Dr. Malin might be suffering severely from the disease to-morrow. Patients should, when possible, be sent away to the mountains or other resorts, where hay fever does not exist.

Dr. Lee replied that sending the patients away for relief was a simple case of *tolle causam.* That is true homœopathy and true practice. If you take away the cause you destroy the disease. This does not, however, destroy the efficacy of the specific homœopathic treatment.

Dr. H. N. Martin asked if the relief from change to high or to low localities, as the case may be, does not constitute a symptom. He once had treated a lady who had asthma when living in Camden, but not when living in Philadelphia. He knew of another case, that of a man who had asthma when in the fifth story of a house, and who experienced complete relief on coming down to

the ground floor. Dr. Martin also expressed himself as believing that the use of palliatives in chronic diseases hindered the cure of the case.

Dr. H. Knox Stewart said that he had had three or four cases of chronic hay fever occurring on or about the 16th of August, in which, by the use of Mercurius corrosivus, he has broken up the attack in ten days. He learned the use of Mercurius cor. in this disease from the late Dr. McClatchey, who gave the remedy in the third decimal trituration until the patient began to feel worse when he changed to the sixth or twelfth. This year Dr. Stewart had had five cases in which the Mercurius corrosivus entirely prevented the return of the hay fever. He commenced to give the remedy about one week before the expected time of the attack. He had used Allium cepa and other remedies with a fair degree of success.

Dr. J. H. McClelland did not think that we should permit our loyalty to principle to lead us to make a misapplication of facts. To say that going away from a certain influence produces a certain effect might be an indication for treatment, is stretching things too much. It is just like saying that in cases of arsenical poisoning the stopping of the arsenic causing the symptoms to lessen, is an indication. We simply remove the patient from the exciting cause.

Dr. Charles M. Thomas said that those of us who make use of local applications have a fair degree of success in entirely curing our patients. Now, the question arises, what is the result of internal treatment alone without local applications. There have been a number of remedies mentioned as useful. Now, how many cases has each one of us cured? Five cases have been mentioned by one physician as having been cured by him. If those cases remain well, that assertion which he has made this morning is a valuable one. But to say that this or that remedy has relieved certain symptoms amounts to very little. The mere change of locality for even a short distance may produce marked amelioration, and even cure. Dr. Thomas said that he would like to hear the practical results of treatment in the hands of those gentlemen who advise the use of the internal remedy alone. His own experience was limited. He had not treated more than eighteen or

twenty cases of hay fever. During the past year he had succeeded by caustic applications to the mucous membrane of the nose along the line of the pasterior turbinated bones, which we find often affected in this disease. In two cases out of eight or ten, he had succeeded in warding off the attack entirely. In one case, he cut down the lower part of the posterior turbinated bone and destroyed the tissue. In another case he used mono-chloro-acetic acid. The question arises, has he done these patients any harm? Still cases have been relieved in this way for a number of years without any bad results. Of course, these cases have also received internal medication, but as he has never seen any benefit from internal medication alone, he concludes that these cures have come from the local application.

Dr. Thomas S. Dunning asked whether it were not possible that many cases of recurring naso-pharyngeal catarrh occurring in the latter part of August are not cases of hay fever. He himself was satisfied that many cases of so-called catarrh are cured that are really incipient hay fever. He had often thought that he had this disease because each August he has an attack of coryza with burning sensations, etc. These attacks disappear under Euphrasia.

THE REPORT OF THE BUREAU OF CLINICAL MEDICINE

Was presented by the chairman, Dr. A. P. Bowie, of Uniontown. The following papers were offered:

Functional Disturbances and Organic Diseases resulting from Lithæmia, by J. W. Dowling, M. D., New York.

The Sphere and Utility of Non-Homœopathic Expedients in the Treatment of Disease, by F. R. Schmucker, M. D., and S. L. Dreibelbis, M. D., Reading.

Clinical Cases, by W. J. Martin, M. D., Pittsburgh.

Clinical Observations and Verifications, by Z. T. Miller, M. D., Pittsburgh.

Œnanthe Crocata in Epilepsy, by Dr. J. Richey Horner, of Allegheny.

Remarkable Case of Typhoid Fever, by Dr. J. Richey Horner.

Notes of Interesting Clinical Cases with Comments, by C. Mohr, M. D., Philadelphia.

Experience with Natrum Arsenicosum in Skin Diseases, C. Van Artsdalen, M. D., Ashbourne.

Clinical Gleanings, A. P. Bowie, M. D., Uniontown.

Cases Showing the Apparently Contagious Nature of Molluscum Epitheliale, E. M. Gramm, M. D., Philadelphia.

Hæmorrhages, by the Philadelphia County Society.

THE FUNCTIONAL DISTURBANCES AND ORGANIC DISEASES ARISING FROM LITHÆMIA.

BY J. W. DOWLING, M. D., NEW YORK,

Professor of Physical Diagnosis, Diseases of the Heart and Lungs, and Clinical Medicine, N. Y. Hom. Med. College.

Lithæmia is a comparatively new name for a very ancient and common disease, and patients will accept a diagnosis of lithæmia and be perfectly satisfied, when if they were told they were suffering from irregular gout, they would doubt the diagnosis, and their confidence in the physician would be shaken, simply because, in their minds, gout is always associated with a swollen, large toe joint and pain. No such condition ever having existed in their cases and believing themselves to be temperate in their habits, of course in their own minds they have not and never have had gout.

The term lithæmia was first introduced into medicine by Murchison, and is intended to indicate conditions resulting from the presence in the blood of waste material in the form of lithic acid. It is claimed, however, by some authorities that lithic or uric acid never occurs under its own form in the fluids of the body, but exists in the form of soluble salts of sodium and potassium; but whether in its own form or in that of these salts, its accumulation in the blood results from disturbances in the chemical function of the liver; and probably also from functional or organic disease of the kidneys, for it is believed that the renal

epithelium in health is active in eliminating uric acid from the blood.

Although arising from the same cause a distinction should be made between gout and lithæmia, and Murchison in his celebrated Croonian lectures delivered in 1874, made this distinction—defining gout as a condition in which the urate of soda crystallized out into the cartilages of the joints and into other portions of the body, giving rise to a train of symptoms familiar to us all and known and described by all of the ancient medical writers as gout. Although every gouty subject at some period of his illness suffers from lithæmia, every lithæmic subject does not by any means suffer from gout.

The condition which is the subject of this paper has been known as irregular or non-articular gout, although unfortunately for patients in by far too many cases, owing to its subtle development and peculiar train of symptoms, the gouty element has not been recognized.

In considering the functional disturbances and organic diseases arising from the accumulation of lithic acid in the blood, the questions naturally arise, What is lithic acid? and why this accumulation in the blood?

In the healthy subject, that great glandular furnace and chemical laboratory the liver, is capable of transforming any excess of nitrogenized matter which may result from metabolism of tissue or exist in the food consumed—into the highly soluble excrementitious substance known as urea. This excrement is eliminated from the blood with which it has become combined, mainly by the kidneys, and to a much less extent, by the skin. In certain derangements of the liver, kidneys and nervous system, but principally of the liver, the nitrogenous waste is not converted into urea but into uric acid, a comparatively insoluble excrementitious and toxic substance. In a perfectly healthy state of the kidneys, this poisonous substance is eliminated with the urine, but in its passage through the urinary tubules, irritation is set up, and if the quantity is large and the irritation long continued, the function of the renal epithelium is impaired and it is not properly eliminated from the system, and consequently, accumulates in the blood.

In perfect health, youth and early manhood, the liver can be

taxed considerably without serious disturbance of its chemical functions, but in the naturally delicate, and in those ill from any cause and particularly during the declining years of life, this organ will rebel at the most trifling abuse, while the strongest liver will sometimes revolt against taxation imposed upon it by the ingestion of certain kinds of food.

This can readily be illustrated by the combustion of the principal product of your own State. You Pennsylvanians know all about coal and furnaces. There are coals which burn in almost any furnace, leaving as before simply fine ashes which will readily pass through the meshes of the finest grate. There are others of a cheaper and poorer quality which, after giving off all that is useful in the way of heat, leave behind a material known as clinkers, which accumulates in and disturbs the workings of the most powerful furnace. So there are foods which are readily digested, never taxing the most sensitive stomachs and livers, and leaving behind but little waste, which must be gotten rid of in the form of excrementitious matter. Then there are foods, some of them rich in nitrogen, which try the strongest digestive organs and leave behind excrementitious waste which in its elimination, will severely tax the various organs concerned in its excretion; food perhaps, which draws so heavily upon the working powers of the assimilative organs as to seriously impair their functions, in time entirely destroying them. The more rational kinds of food which supply all of the requirements of the system, may be compared to the coal of better quality, the urea and other readily excreted refuse matter remaining, to the fine ashes which, with ordinary care, never accumulates and never disturbs the working of the furnace, until, from the natural effects of age, it is no longer competent to do even ordinary work. But it is a fact, familiar to us all, that too large a quantity, even of good coal at any one time, will clog the furnace and interfere with proper combustion, so will too great a quantity of good and rational food, at any one time, disturb the functions of the liver, stomach and intestinal canal.

The power quality of coal may be likened to food too rich in nitrogen and to irrational articles of diet which disturb the stomach and derange the liver; the refuse matter of the coal, in the form of clinkers, to uric acid which accumulates in the system, by its pres-

ence disturbing the functions of all the organs of the body developing organic diseases in many of them and permanently injuring, perhaps ruining, the kidneys in their efforts to eliminate it from the system. We have all experimented with such coal in our house. We have all, time and again, taken such food into our stomachs. It is no exaggeration to say that nearly if not all of the cases of that form of Bright's disease, known as chronic interstitial nephritis, are caused by the presence in excess in the blood of this excrementitious substance, known as uric or lithic acid, and that by far the greater number of cases of chronic catarrh of the bladder, in middle and advanced life, and nearly all of the cases of renal and urinary calculi, result from the same cause.

The comparison which has just been made between coal and food, and the two waste materials, ashes and lithic acid, if not supplemented, would rather imply that coal and food were the only factions on which depended the proper working of the furnace, and the nutrition of the body. Ever since "fossil fuel" (as coal was originally called) was first discovered and its nature understood, the genius of man has been taxed to invent and improve upon methods of easy combustion of this material. Tall and expensive chimneys have been erected and every pains taken to construct furnaces which would give out the greatest quantity of heat, with the smallest consumption of coal, until now it seems as if perfection had been reached. As there are powerful and weak furnaces, so there are naturally strong and weak livers, stomachs and kidneys; weak, not from individual indulgences, but from hereditary influences, and undoubtedly owing to indiscretions of parents or their ancestors, for I believe that the divine law, "The iniquities of parents shall be visited upon the child unto the third and fourth generations," will apply here as in iniquities of other and a graver nature. In these subjects, even in early childhood, we have frequently well marked lithæmic conditions, from the inability of the liver to perform its ordinary functions, the lithic acid crystals frequently being found in the urine, in the form of lateritious deposit or the so called brick-dust sediment.

A remarkable example of this kind came under my notice a few months ago. A bright little girl of eight years of age had suffered since she was an infant at the breast with occasional at-

tacks of loss of appetite, derangement of the stomach, constipation, sleeplessness, palpitation of the heart, and unnatural excitability and irritability. These attacks were always accompanied by diminished flow of urine, which became cloudy almost before cooling, and finally deposited a quantity of lithic acid in the form of brick dust. As she improved, the urine became free, the deposit disappeared, and all of her unnatural symptoms, aside from the constipation, would subside. During the illness, there would be no elevation of temperature; the excess of uric acid was not, therefore, owing to increased metabolism of tissue, resulting from fever. The child's father had been a gouty subject through life by inheritance and personal indiscretions. The mother was a lithæmic subject, and had been long before the birth of this child, the condition in her case resulting from an indolent, fashionable life and participation for a series of years with her husband in the pleasures of the table. Neither father, mother nor child showed, on physical examination, any evidences of organic disease of any of the viscera. If my directions with regard to exercise, habits of life, total abstinence and diet are carried out, I believe they will all finally recover; if not, in the "sweet by and by," if they live to see it, there will scarcely be a sound organ in any of them. In this case, the iniquities of the parents were visited upon this child, for it had had the best of care, only one mistake having been made that I could discover, and this was an excessive quantity of meat with its diet ever since it left the breast. Heredity as a factor in the etiology of gout has been conceded since the days of Hippocratés, but unfortunately, with the inheritance of this tendency to a uric acid producing liver, comes by heredity and example, a tendency to indiscretions which would produce the disease in a man perfectly healthy and born of parents who, with their ancestors, had earned their bread by the sweat of their brows, and who had always been too poor to indulge in so extravagant a luxury as the gout. It has long been known that lead poisoning is accompanied by excessive generation of lithic acid and its imperfect elimination.

There is no denying the fact that a large portion of the ills to which man, and woman, too, are heir, results from the presence in the blood of an excess of waste material in the form of lithic acid,

and that this excess results in by far the greater number of cases from actual indiscretion, violation of nature's laws. Many of the so-called cases of neurasthenia—the new name for the fashionable and flattering disease, nervous prostration or exhaustion—are cases of lithæmia, which can be cured,—this I know to be a fact,—by proper diet, the avoidance of stimulants and drugs, and a proper amount of physical exercise, and, with some, more brain work, for I believe that brain work is as necessary to some men as is physical exercise to others. It is painful to see in our large towns and cities the number of men and women whose main object in life seems to be to kill time. Instead of their chronic ailments arising from nervous exhaustion or prostration, it is more than probable that they arise from stomach and liver exhaustion. I have had lazy, indolent and ignorant men and women come to me with a diagnosis of neurasthenia from mental strain, who for years, have neither worked brain, legs or arms, the only muscles which they have ever tired by exercise having been the masseter; and yet these patients have accepted from physicians, without cavil, a diagnosis of nervous prostration, and have been pleased and flattered with the thought. So, too, with the highly popular disease, malaria and malarial cachexia. Many of these malarial subjects are suffering from lithæmia, and are cured by the method just mentioned. It is true that malarial cachexia often complicates lithæmia as it does other diseases, and the periodic aggravations naturally lead to a diagnosis of malaria, but if we regulate the habits and diet of our malarial patients, stop this quinine and restore the function of the liver, or give nature a chance to do it, the system will be brought to a proper level of health, and the malarial poison will be inactive. It is to be remembered that it is not by any means certain that the periodicity of many of these so-called malarial conditions is owing to the presence of the malarial germ in the system. Malarial diseases are not the only ones characterized by periodic exacerbations. How often are cases of phthisis mistaken for malarial illness and diagnosed as such by attending physicians because the patient has passed a summer in a malarial section and suffers from a daily chill, rise of temperature and sweat? We have all seen cases of phthisis where no careful physical examination had been made, the true nature of the malady

not having been suspected till the disease was beyond the control of remedial measures.

Only a few months ago a lady presented herself at my office, who for some weeks had had a daily chill appearing about two P. M., this was followed by subjective heat lasting for a few hours and succeeded, about six P. M., by a profuse sweat. She hesitatingly acknowledged to having a hacking cough and some expectoration, but laughed at the idea of pulmonary trouble. No such disease had ever been known in her family. She had been told and was convinced that her trouble was intermittent fever, and it is not surprising that such a train of symptoms, without a careful consideration of the case, had deceived the physicians who had treated her. The quantity of quinine she had taken was enormous, no benefit had been derived from its use, and at the time of her visit she was taking large doses of Fowler's solution of arsenic. Physical examination proved conclusively that the patient was suffering from tubercular phthisis. She has since died.

Another familiar example of periodic symptoms in other than malarial diseases, is the daily chill, fever and sweat accompanying extensive suppuration going on in any part of the body.

It is an established fact that in like manner some of the functional disturbances known to arise from an excess of lithic acid in the blood, and too in patients who have never been exposed to miasmatic emanations, are most prominent at certain regular periods of the day.

In what has already been written, I have referred in a general way to the etiology of this disease, and have ascribed it, in the cases not arising from hereditary influences and lead poisoning, to indiscretions in living. In what do these indiscretions consist? In a former article, prepared two years ago for the American Institute of Homœopathy, entitled "The Effects of the Abuse of Alcohol on the Circulatory and Respiratory Organs," I considered very carefully the effects of the indiscrete use of this poison and attributed many of the cases of organic disease of the heart, arteries and respiratory organs to a lithæmic condition resulting from its use. Two more years of extensive experience with these diseases have confirmed me more and more in my belief that the continued use of this poison in any of its forms through its primary effect on

the liver, produces organic disease of all the viscera, diseases which embitter and shorter life. Aside from its direct toxic effects on other organs it disturbs the function of the liver to such an extent that this organ is unable to convert nitrogenous waste in the system into urea, and lithæmia is the result.

Next in the order of importance as a factor in the production of this disease is the too free use of nitrogenous food, the liver under such circumstances being unable to convert the excess into urea. It is true that large quantities of meat have been taken with impunity by many invalids, and even good results have followed, but in these cases all articles of diet having a tendency to tax or irritate the stomach have been excluded and several pints of hot water have been taken daily with the diet of meat, and have probably prevented the formation of uric acid or acted as a solvent for it so that it has not accumulated in the system.

Then come indiscretions in diet which have a tendency to disturb the stomach, developing chronic catarrh of that organ and dyspepsia, by which substances are generated in the stomach which by their absorption and passage through the vessels of the liver, poison that organ and disturb its function so that instead of waste material being converted into urea, uric acid results, which enters the general circulation and is not properly eliminated by the kidneys. It should be noted that authorities now agree that there is a uric acid secreting function of the kidneys, if the kidneys are injured by the presence of an excess of this material circulating in the blood vessels of their parenchyma or by other causes, changes take place in the renal epithelium which results in temporary or permanent loss of the uric acid excreting function. Excessive production with diminished power on the part of these excretatory organs to eliminate uric acid necessarily results in a permanent accumulation of the poison in the blood.

The next, and a most potent factor, in the etiology of lithæmia is an indolent, lazy life—even with a diet of mush and milk. For the liver to work properly, exercise of the body—and perhaps of the mind—is imperative; if its function is disturbed lithæmia necessarily results.

One of the worst cases I ever examined was in a man, a model man, of most exemplary habits. He never drank, never smoked,

never ate any meat, at least he had been a vegetarian for years when I saw him, and he supposed there was nothing left, so far as this world was concerned, to make him perfect in his habits. He always rode in the horse cars to his business, sat at his desk writing and counting money till noon, ate a plain lunch of farinaceous food and fruit in his office, returned to his desk immediately, worked all of the afternoon, rode to his home in the cars, ate a hearty dinner of vegetable food, and spent the evening in his room, except on church nights, when he always attended divine service. He lived next door to the church. He amassed a fortune, grew fat, short-winded, dropsical, and finally died, a bachelor, of fatty degeneration of the heart. When I saw him almost his first remark was: "I can't understand, doctor, why I am in this condition, for I have led a most exemplary life." The tortuous temporal arteries and other external evidences showed that he had been a lithæmic subject for years, the condition having been brought about by direct violation of nature's laws, by which the function of the liver and kidneys had been permanently ruined, the fatty degeneration of the heart resulting from malnutrition of that organ arising from atheroma of the walls of the coronary arteries and their branches.

Functional Disturbances Resulting from Lithæmia.—With a toxic element circulating in the fluids of the body it is hardly to be expected that any of the organs should escape its influences; and a close study of this disease and a large experience, both in my consultation and general practice, in the investigation and treatment of lithæmia and the organic diseases resulting from it, satisfy me that such is the case. The entire nervous system is affected by the presence of this poison (lithic acid) in the blood. As was before remarked, many of the so-called cases of neurasthenia are cases of lithæmia, and can be cured by eradicating this poison from the blood; and the etiology of many cases of insanity can be cleared up by carefully considering the antecedents of the patients as regards the indiscretions of life and hereditary influences, not with special reference to insanity, but lithæmia, gout and renal and urinary calculi.

The digestive organs always suffer, although the lithæmic patient may not be aware of the fact, for in the absence of prominent gastric symptoms, particularly if the bowels are moved daily, he will

hardly suspect derangement of the liver function, and that of other organs concerned in digestion and assimilation. Prominent, also, among the functional disturbances arising from lithæmia are derangements of the circulatory and respiratory organs, resulting later in incurable organic disease. The urinary and genital organs in both sexes, in chronic cases of the disease, are rarely exempt from its influences. Renal, bladder and urethral catarrh I have frequently found in men and women, and loss of virile power, with prostatic enlargement, is a most frequent accompaniment in the male, and in the female functional disturbances and organic diseases of the generative organs occur, while hæmorrhoids are common in both sexes.

In Fagge's "Practice of Medicine," under the head of Hepatic Dyspepsia, may be found Murchison's tabulated arrangement of the prominent symptoms of this disease. Bitter or coppery taste in the mouth, especially in the morning, intestinal hæmorrhage, neuralgic pains, feelings of oppression and heaviness, creeping sensations, aching pains in the limbs, lassitude coming on after meals, sometimes accompanied by irresistible drowsiness, severe cramps in the legs and in different parts of the body, headache characterized by a dull, heavy pain, seated in the forehead, or more rarely in the occiput, giddiness or swimming in the head, particularly when the patient stoops or lays his head upon the pillow, often passing off in the erect posture; tendency to grind the teeth during the waking hours, passing off while the patient is asleep. Convulsive attacks, simulating epilepsy, are sometimes due to the same cause; noises in the ears of various kinds, muscæ volitantes; sleeplessness, unquiet dreams, depression of spirits, irritability of temper, palpitations and fluttering of the heart, exaggerated pulsations in the large arteries, irregularity and intermissions of the pulse, chronic catarrh of the fauces, chronic bronchitis and spasmodic asthma, pains in the lumbar regions, distention and tightness in the epigastrium after meals, dull aching in the right hypochondrium, and sometimes shooting pains in the same region; sense of weight and fullness below the ribs, often increased by lying on the left side; the hepatic region may even be sensitive to pressure; pain in the right shoulder, sometimes in the left. Often the conjunctivæ have a slight yellow tint, and the skin may even display traces

of the same color. The urine is sometimes scanty and high-colored, as it cools depositing large quantities of lithates of bright red color. Again, the urine may be clear, large in quantity, and of low, specific gravity. The bowels may be constipated or the patients may be troubled with frequent semifluid discharges. A common and almost one of the most frequent symptoms of chronic lithæmia is a disposition to urinate during the night. It is found, on questioning, that nearly all patients suffering from this disease are obliged to rise during the night once, twice, or even more frequently to urinate, not because the accumulation is large, but owing, probably, to hyperæsthesia of the sensory nerves of the bladder, and to the irritating quality of the urine and its effects either upon the walls of the bladder or the nerves of the kidneys.

Before considering the organic diseases known to arise from long continued excess of waste material in the form of lithic acid in the blood, I will select a few cases from my record book illustrating the functional disturbances of lithæmia, cases which, on physical examination, showed no evidences of organic disease in any portion of the body.

Case I.—Mrs. H., a strong, healthy-looking woman, but with a superfluity of adipose tissue, fifty-three years of age, living in the country. Of late years, her circumstances have been such that it has not been necessary for her to do her own household work. Has a good appetite, eats largely of meat three times a day, and for the past three or four years has taken a bottle of lager at dinner and another before retiring to bed at night. Formerly active in her habits, but now takes but little exercise; drives occasionally, but spends most of her time within doors sewing and reading. Family history good. Till three years ago always perfectly healthy, with the exception of an attack of inflammatory rhematism twenty-five years ago, from which she entirely recovered. Has had but one child, who is now seventeen years of age; never had any miscarriages; still menstruates, of late every three weeks; for two days the flow is quite profuse; at these times she suffers from great weakness—she thinks from the loss of blood. Present condition, which has been her general state for the past three years: Complains of "nervousness," remarkably irritable for her, annoyed by trifles, constantly depressed in spirits, suffers from in-

digestion, with distention of the stomach, belching of wind, and intestinal flatulency; constipation, is obliged to resort to cathartic remedies to have a movement from the bowels; sleep disturbed by disagreeable dreams; awakes suddenly from her sleep frightened; rises in bed, then her heart will beat violently; this subsides after a while, but it will be a long time before she gets to sleep again, and then her sleep will be restless and disturbed; always rises two or three times in the night to urinate, and the urine is high-colored and deposits large quantities of sediment, sometimes whitish in color, but generally looks like brickdust; has occasional attacks of neuralgia, commencing in the præcordial region, accompanied by violent action of the heart, the pains passing up over the shoulder and down the left arm, paroxysms lasting from two to ten minutes; more apt to come on during the menstrual periods.

By these symptoms, her life was rendered miserable. The fact of the patient having had inflammatory rheumatism, and of her suffering from paroxysms resembling angina pectoris, prompted me to make a thorough physical examination of the heart, which was found to be perfectly normal, as was every organ which could be reached by physical exploration. The specific gravity of the urine was high (1026), loaded with lithates, but free from albumen and sugar.

I was inclined to attribute her condition partially to climacteric influences, but decided to direct my treatment towards a regulation of the hepatic function, feeling that a woman of so strong a constitution should pass through the climacteric epoch without serious disturbances. I ordered total abstinence from alcoholic beverages of any kind, a diet mainly of farinaceous food, fish and fat bacon, meat in very small quantities, and never more than once a day, and excluded beef entirely from her diet, preferring lamb, the breast of chicken and turkey. I ordered exercise, a brisk walk (rain or shine), moderate at first, but increasing gradually till she could walk five miles a day, and large draughts of hot water four times a day.

It is now twelve months since she came under my care. Her menses still continue, but the quantity of blood lost is much diminished. She has had none of the paroxysms of "neuralgia." She sleeps well without dreaming; her bowels are regular, her urine

free from deposit. Her appetite and digestion are good. She has no more flatulency. She does not suffer from depression of spirits or nervousness. In fact, she is a well woman. The only remedies she has taken are *Nux vomica* and *Berberis*. She has followed my directions carefully, and still continues the mode of life I laid out for her at my first examination. This was a typical case of lithæmia, resulting from luxurious, lazy living, with indiscretions in eating and drinking, cured by regulating her habits of life and assisting nature by homœopathic remedies, indicated by her condition and symptoms.

My remedies received the credit, but the cure was effected by the change in her mode of life. The *vis medicatrix naturæ* was strong enough, with a little assistance, to effect a perfect cure if it could only have an opportunity, unhampered, to make the effort. It is not always that patients will adhere so religiously to a doctor's prescriptions. You have all heard the story told of Abernethy, who had been trying in vain to relieve a distinguished but gouty nobleman of ailments arising from the indiscretions of life. "I should advise you, sir, to steal a horse," the doctor said. "What do you mean, doctor? I did not come here to be trifled with." "I am not disposed to trifle with any one, sir. Steal a horse." "Why, doctor, what do you mean?" "I mean, sir, if you steal a horse you will be placed where you will have proper food, a proper amount of exercise—where you will be obliged to retire at the proper time for going to bed, and be compelled to rise early in the morning and go to work. In brief, you will be placed where you will be made to lead a decent, rational life; and this is all that is needed to make a well man of you, sir. Steal a horse."

Case II.—A lady of great refinement, surrounded by every luxury which wealth could afford, the wife of a good husband and the mother of a large family of children, all grown. The history of her case was as follows:

Never had employed a homœopathic physician; in fact, one of her sons was an old school doctor. Family history good. Had had no serious illness, and had been well till within the past five years, during which time she had been a confirmed dyspeptic; was nervous, depressed in spirits, sleepless, generally constipated, but occasionally troubled with diarrhœa; suffered from a dull pain

in her head during the first half of every day; weak and unable to exercise on account of severe pain in the lumbar region; a bearing down sensation in the lower portion of her abdomen; inability to take much food on account of distress in the stomach, which comes on after eating, and described as a feeling of distention and weight, and accompanied by belching of wind; occasional cramps in the abdomen, generally confined to the left side beneath the ribs; dull pain and fullness in the right hypochondrium; tongue swollen and covered with a slimy fur; rises at least twice every night to pass water, and the urine is always dark-colored and deposits a thick, reddish sediment.

Physical examination showed no evidences of organic disease, but the finger joints were enlarged from deposits of urate of soda. For some weeks prior to my being sent for she had been confined to her room, the most of the time to her bed, with diarrhœa and its debilitating effects, each passage being preceded and accompanied by pain in the bowels. She had been under the care of an old school physician, who had prescribed astringent remedies and opium for the looseness of the bowels, and brandy and hypnotics of various kinds for the sleeplessness, which had been very distressing of late. I learned that for many years, it had been her custom to drink wine with her dinner, and in addition to this, she had taken a little whiskey or brandy before meals for the dyspepsia.

The character of the urine, the enlarged finger joints, and the general symptoms led me to a diagnosis of lithæmia. In the management of her case, I stopped all of the palliative drugs, cut off the brandy and wine and placed her on a diet of milk and farinaceous food, cutting off all meat. Of course, for a few days she missed the palliative drugs and the stimulants she had been accustomed to; then, with an occasional dose of the remedy indicated by her symptoms as they showed themselves from day to day, she commenced to improve. In six weeks from the time she came under my care, she was comparatively a well woman. Nearly all of her distressing symptoms had disappeared, the urine had cleared, and she was having one natural movement from the bowels each day. The patient remains well. In the absence of other causes, I attributed her lithæmic condition to disturbances mainly

resulting from her daily allowance of alcohol, the palliative drugs she had taken, and to excess of nitrogeneus food, for she had been a hearty meat eater through life, and I attribute her recovery to the entire change made in the mode of life.

These are but two of many such cases which have been treated or examined by me during the past few years. And I am not exaggerating when I say that in the absence of organic disease, if the patient is willing to follow directions as to exercise, diet and mode of life, with but little aid from medicine all can be entirely cured.

Of course where organic disease results from lithæmia the case is different. Such patients cannot be cured, but many of the cases are, to a certain extent, amenable to treatment with the result of arresting the progress of the disease and improving the general condition so that life instead of being a burden is at least endurable.

Among the organic diseases known to result from lithæmia or, what in this connection is the same, from high living—indiscrete living—including the long continued use of alcoholic beverages, even in small quantities, intemperance in eating, sedentary habits, long continued mental strain and worry, may be mentioned first and most common, chronic interstitial nephritis, chronic catarrh and hypertrophy of the walls of the bladder, chronic prostatitis, chronic pyelitis—from the accumulation of lithic acid crystals and the formation of renal calculi in the pelvis of the kidneys—stone in the bladder, atheroma of the arterial walls in various parts of the body with its terrible consequences, including hypertrophy of the muscular walls of the heart, although this latter condition can hardly be called a disease, for in every instance it is compensatory, in this to compensate for the narrowing of the calibre of the arterioles resulting from fibroid changes and obstructions owing to atheromatous changes in the walls of the larger vessels, aneurisms, large, small and capillary, the latter particularly in the substance of the brain which, by their yielding, result in cerebral hemorrhage, the apoplectic attack being sometimes the cause of sudden death; valvular disease of the heart and peri- and endocarditis; fatty degeneration of the heart walls—a most common cause of death in lithæmic subjects—chronic pharyngeal, laryngeal and bronchial catarrh resulting from the latter, pulmonary vesicu-

lar emphysema, broncho-pneumonia and chronic interstitial pneumonia or the so-called fibroid phthisis; various chronic diseases of the stomach and intestinal canal, hæmorrhoids and fistula in ano; and I am convinced from observation of cases which have been under my own care that many serious organic diseases of the nervous system result from lithæmia. Two cases of progressive locomotor ataxia which I have treated have, in my opinion, resulted alone from this cause.

If time would permit I could give you examples of all of the organic diseases mentioned resulting, I am positive, from lithæmia, all having been under my own personal observation and of which I have kept an accurate record, but my paper is already too long, and I will cite but three, two of organic disease of the heart and one of the kidney.

Case I.—In September, 1881, I saw, in consultation with Dr. Pratt, of New York city, a gentleman, 39 years of age. From his appearance in good health, but complaining of symptoms which led me to a careful examination of his heart. The walls of the left ventricle were hypertrophied and there was a double murmur at the aortic orifice, systolic and diastolic, showing constriction of the orifice with insufficiency of the valve. The urine was albuminous and he subsequently died of fatty degeneration of the heart, the death process being slow and tedious—the immediate cause being pulmonary œdema.

The history of this man's case was as follows: Family history: father died of apoplexy at the age of 59; mother living and well; no history of disease in the family likely to be hereditary.

Personal history: Started out in life with a strong constitution; never suffered from any serious illness aside from those of childhood, from which he recovered nicely; always strong and equal to any amount of mental or physical work. From time to time for some years past, has had symptoms which he supposed arose from malaria, and for which he took large doses of quinine. From boyhood has had a good appetite and has always eaten largely of meat. For many years, has been in the habit of drinking wine with his dinner, and brandy or whisky at all times during the day or evening when the opportunity offered. "Never was drunk in his life." Never had rheumatism or gout. An active politician

and a leader, a few months prior to his visit to me he passed through a very exciting campaign, and on the occasion of a political parade he had the entire work of the arrangements on his shoulders, and was on horseback from seven A. M. till two the next morning. For an hour before dismounting he had a pain across the sacrum; this increased in severity and was painful all the next day. There followed this violent action of the heart, dyspnœa on exertion and œdema of the feet. His progress was steadily downward, and he died in the following fall of fatty-degeneration of the heart as above stated.

He had complained of many of the symptoms of lithæmia; for years had risen two or three times in the night to urinate, and the urine was generally high colored and frequently deposited a reddish sediment.

This man had undoubtedly been a lithæmic subject for years, and in the absence of other common causes of valvular disease of the heart it is fair to presume that his organic disease resulted from fibroid changes at the root of the aorta extending to the valve and this was brought about by lithæmia, his habits of life were one constant violation of nature's laws; the exciting cause of the final breaking down being long continued over exertion, mental and physical.

Case II.—The case I am now about to relate has not as yet had so serious an ending. And from a proper diagnosis having been made, and the fact that the patient has been convinced that the cause of his troubles was indiscretions of various kinds, this conviction having led him to an entirely different mode of life. I am hopeful from his present improved state, that he may be spared in fair health for many years to come, although he can never be perfectly well, and is liable at any time from an error in diet to have a return of his symptoms, and an aggravation of his disease which may result fatally.

The history of the case is as follows: Family history: father gouty, suffered from sciatica during the latter years of his life, and finally died of softening of the brain. Mother always well and lived to a good old age.

Until two years ago the patient had been in the enjoyment of good health as he supposed. Suffered from insomnia at times,

and occasional nervous symptoms and dyspepsia, but these were generally relieved by palliative drugs and alcoholic stimulants. For over twenty years had been a heavy drinker of wine and the stronger alcoholic beverages. "Never was intoxicated."

Three years prior to my examination while at the theatre he was seized with a severe pain in the back; relieved by a hypodermic injection of morphia. Recovered from the paroxysm and seemed in his usual health, aside from occasional slight pains at the seat of the original trouble. One year from the date of the first attack, was again taken with the same character of pain, confined to the region of the right kidney; this was accompanied by nausea and vomiting. From that time on for two years was never well; constant pain extending entirely through the abdomen to a point about two inches below the margin of the ribs. Sometimes these pains would be very severe, sharp and cutting, then they would modify, but never entirely leave him; the liver, also, was sensitive and painful on pressure. He was always nauseated, his appetite was poor, and only the simplest kinds of food were retained, his skin became sallow, he lost flesh, and his nights were deprived of continued sleep. He was unable to attend to business, and longed for death. Brandy and whisky were continued, for they were the only things which afforded any relief. Old school physicians prescribed palliatives but with no permanent benefit. After a careful examination of his case I gave a diagnosis of pyelitis with great enlargement of the right kidney; this enlargement I could make out by palpation, and an examination of the urine showed pus corpuscles and blood discs in abundance, with large quantities of lithic acid crystals. The urine, also, contained albumen in greater quantities than could be accounted for by the pus and blood globules. As casts were found Bryonia^{3x} was given and electricity administered [faradic current] one electrode being applied over the affected kidney and the other anteriorly at the seat of the pain. Much to my surprise he passed a comparatively comfortable night, sleeping fairly well and having but little pain. The following morning he passed, with his urine, large quantities of lithic acid in the form of a coarse brick dust sediment. This had evidently been impacted in the pelvis of the kidney. I placed him on a non-nitrogenous diet, and deprived him of everything in the form of alcoholic

drinks, and, of course, stopped all palliative drugs. His improvement has been steady. A year has now elapsed; during this time he has had two attacks of renal colic but at the present time thinks he is in fair health. Under date of Aug. 11th he wrote me, "For a well man I am well; for me splendid." His urine, however, still contains pus and albumen, showing that he is by no means a well man. From this condition of chronic pyelitis he will probably never recover, but with his present careful mode of life he may live for many years in comparative comfort.

CASE III.—Since commencing this article the sister of this gentleman has placed herself under my care. She has a history of excess in the use of wines, and of nitrogenous food, sleepless nights and dyspepsia for years. No serious illness till the present one, which she describes as follows:

On July 3d was taken with a severe pain in the back of the neck, which extended to the head. Shortly after this, in the night, was seized with a dreadful pain in the præcordial region, coming on in paroxysms. She could not breathe for the pain; at times it would extend to the back and dart through the entire spine. This lasted for some six weeks, with intervals of freedom from pain. This has now entirely left her, but she is troubled with great shortness of breath, on the slightest exertion; had to stop several times in coming from the horse cars at the corner to my office, a distance of not over one hundred feet. She has a feeling of dreadful oppression in the præcordial region, with violent, irregular and rapid action of the heart; complains also of numbness of the hands and feet.

The patient is well nourished, hair of an iron-gray color, although she is only forty-six years of age, menstruates regularly. The urine is scant, contains no albumen, but is very heavy and loaded with lithates. Physical examination showed her to be suffering from stenosis of the aortic orifice of the heart, with all of the evidences of fatty degeneration of the heart walls. There was a fatty arcus senilis on the upper border of the cornea, and the pulse at the wrist was scarcely perceptible, rapid and very irregular. She will, in my opinion, never rally.

Both of these patients had been suffering from lithæmia for years, largely brought about by their own indiscrete living, but

partially owing to hereditary predisposition, the father, it will be remembered, having been a gouty subject through life. Possibly the first case was aggravated by hereditary taint, for the father had died of apoplexy, and this usually indicates a previous life of excess in eating, drinking, etc.

In the treatment of lithæmia and the organic diseases resulting from an excess of lithic acid in the blood, we sometimes have to arrive at a diagnosis by exclusion. There is a cause for every morbid condition, and there are habits of life, atmospheric influences and occupations, which give rise to certain diseases and aggravate them if they already exist.

The first step towards treatment is to make a positive diagnosis, then to see if we can learn the causes of the disease, and to learn whether the life of the patient is such as to permit us to labor untrammelled with our remedies and measures for his relief. Then we should correct the mode of life, if we find need for it, and insist upon the patient aiding us by his own efforts to effect a cure, if a cure be possible, or to arrest the progress of the disease, if it is of an incurable nature, and thus make his life as comfortable as can be under existing adverse circumstances.

If a patient consult us suffering from the symptoms given above, or from any of the organic diseases mentioned, we should make careful inquiries, to learn if other known causes exist. If we find they do not, on further inquiry we will learn of indiscretions which have given rise to or are aggravating the condition, and a careful examination will lead us to a diagnosis of hepatic disturbance, by which waste material in the blood, instead of being converted into urine, which is readily eliminated, is by imperfect oxidation converted into lithic or uric acid, and retained in the fluids of the body. The treatment is then simple enough: Correct indiscrete habits of life, lay out a proper course for the patient to pursue, and help nature by the administration of the carefully selected homœopathic remedy. If in doubt as to the special mode of life and diet in an individual case, advise, on general principles, a life and diet which we know to be harmless, as did the pioneers of homœopathy. Professor Small used to say to us in the lecture room: "Gentlemen, if you are in doubt as to the remedy in an individual case give Sulphur high. It is a general corrective and can do no

harm, and it is more than likely it is just the remedy the patient needs."

In closing this subject of treatment, and with it this paper, I propose asking a pointed question: Are the average homœopaths of to-day as successful in the treatment of disease as were the pioneers of half a century ago? By contrast with the results accomplished by the old school of now and then, certainly not. If this is conceded, the question naturally arises, Why? Many factors will enter into the answer to this question. The first and most cogent reason is undoubtedly the revolution which has taken place in the treatment of disease by members of the old school. All familiar with the history of medicine for the past half century know in what those changes consist. Far into the period mentioned the generally conceded irrational, violent, murderous system prevailed. Then came the expectant, and now the physiological, largely mixed with the homœopathic system, is adopted by all of the old school who are abreast of the times.

Then, again, I believe the change, so far as contrast is concerned, is partially owing to the fact that the members of our own school are not, as a rule, as careful in the selections of their similimums; instead of studying the materia medica they read the old school journals. Then our improved knowledge of pathology is perhaps another factor, and this in itself will, to a certain extent, excuse the laxity which exists among some of our practitioners with regard to the selection of their remedies in accordance with the homœopathic law of cure. There are those present who will perhaps disagree with me in the belief that this can, under any circumstances, be an excuse, but with some it is hard to reconcile certain supposed pathological laws with the law propounded by the father of our school—the law by which, as homœopaths, we profess to be guided. The temptation to resort to physiological pharmaceutics with such is very strong.

Another, and by no means the least important, factor in the cause of the lessening of the contrast in the results of treatment, so far as the two schools are concerned, is the fact—for it is a fact—that the average homœopath of to-day is not as careful in the dietetic rules laid down for his patient as was the pioneer. Then, printed rules, general rules, were given to every patient; certain

articles of food and drink were strictly prohibited, in the minds of the patient and, too, in that of the physician in many instances, because these articles would antidote the medicines given. On this ground patients were willing to abstain from tea, coffee, condiments of all kinds, tobacco, alcoholic beverages and palliative drugs. It is a pity that this idea does not prevail at the present time, for, although the articles mentioned may not antidote the drugs, they certainly do interfere with the health of the patient, and too frequently are the cause of the very disease we are endeavoring to cure.

As homœopaths, we claim that God has given us a law for the selection of drugs by which all curable diseases may be cured, but has He not also given us laws with regard to diet and habits of life, which, if violated, sooner or later lead to disease? Is it rational for us to prescribe, in accordance with one Divine law, medicines to cure a train of symptoms resulting from the violation of another Divine law, while that law is still being violated? Certainly not. In studying the pathogeneses of drugs, let us study hygiene, and then from positive knowledge lay down our rules and endeavor to see that they are followed. Make our patients follow the good old rule—eat and drink each day what is necessary to satisfy the requirements of the system, those requirements being merely to replace in the body what is lost by muscular contraction, mental work, etc. And in enforcing these rules upon our patients do not let us forget that we will be better men, better husbands, better fathers, better Christians, better doctors, if we follow them ourselves.

CLINICAL CASES.

BY W. J. MARTIN, M. D., PITTSBURGH.

1. *A Case of Weak Dilated Heart.*—An old gentleman, aged 65 years, had been ailing for more than a year, but had never consulted any physician, taking sometimes some patent nostrums.

When I was called to him his condition was as follows: No appetite, tongue and mouth foul and slimy, breathing wheezing, cough, dyspnœa, very great difficulty in ascending steps, cannot

lie down, must sit up all night, smothers when trying to lie down. Heart enlarged and its action very irregular, weak and tumultuous, the pulse cannot be counted, sometimes there will be three or four regular beats, then a period of irregular beating, then a few regular beats, and so on. The urine very scanty and black as coffee, feet, ankles, and legs to the knees very much swollen.

The man had always been a hard drinker, though probably hardly ever drunk; one of the steady drinkers. I did not think I would be able to improve his condition much, and the fact that he has recovered a very fair degree of health is my reason for giving the treatment of this case.

He has now a good appetite, passes a normal quantity and quality of urine. The swelling of the limbs is all gone except a little about the ankles. He can lie down in bed and sleep good all night, and his heart beats 72 good regular beats every minute (when he does not exert himself).

The treatment was first Nux vom. for a few days, then he was put on Digitalis[1], ten drops in a glass half full of water, a dose every two hours. After taking this for three days and getting worse all the time I changed to Iodide of Arsenic[3x], one grain (equivalent to $\frac{1}{1000}$ of a grain of the crude drug) every two hours. Improvement set in very soon and continued, his present condition being as I have described.

2. *A Case of Carbuncle.*—I was called to see a lady, aged about 36, who said she had been suffering for a week with something like a boil on the side of her chest, that the pain had been so intense for two nights that she could neither sleep nor stay in bed; she walked about and feared she would die or go crazy if the pain continued much longer, nothing she had applied or taken had the least effect in mollifying her suffering. The location of the sore and the woman's modesty had caused her to suffer so long before calling for help from a physician (and when I tell you the remedy prescribed and from which she got almost magical relief, you may wonder, as I did, what the self-styled "regular" physician would have done in the way of relieving this most painful case). On examination I found that her boil was a veritable carbuncle, as large around at its base as a silver dollar, elevated like a small mountain, the top of which was studded with small openings. No pus

discharging, pains intense, burning and stinging, extending to the mamma and down the arm, and she had not had one moment's sleep for over forty-eight hours. Tarentula Cubensis[12], a dose of six No. 30 pellets, every hour, was prescribed, and a cold slippery-elm poultice applied. After the third dose of the medicine, her pain was noticeably less and she slept all night. The pain got less and less till there was only soreness when touched on the affected part. Pus formed in the carbuncle and the centre sloughed out, the opening thus made rapidly closed up and the whole trouble was over in two weeks from the time of taking the first dose of the Tarentula. No other medicines were prescribed.

3. *Cough Cured by Manganum Met.*—A lady consulted me last spring for a cough with which she had been troubled all winter. It was a dry, almost constant, cough, with irritation under the sternum, and aggravation from talking, laughing, walking, and deep inspiration. She said she had taken a great deal of Phosphorus which she purchased at the Homœopathic pharmacy, and that it always helped her but did not entirely cure her. I gave Phos.[200]. In a week she reported no better. On closer questioning to get more symptoms, she gave me this peculiar and important one: *her cough is always better when lying down; it will stop when she lies down and not trouble her again till she gets up.*

I had read several years ago in the *Hahnemannian Monthly* a little article from the pen of the late Prof. Farrington, giving the cure of a cough with this unusual symptom, by Manganum met., and I had not forgotten it. I gave my patient the Manganum met.[12], a dose every four hours, with the happiest result. When she called again her cough was better and has never returned.

4. *Diarrhœa Cured by Hyosciamus.*—Mrs. R. was recently confined. Having had a hard labor and being a weak, nervous person, she was in bed for several weeks. The third week she was able to be up and move about some, when she was suddenly and unexpectedly, and without any apparent cause taken with a diarrhœa. The stools were involuntary, unconscious, painless, yellowish, watery. After taking a few doses of Hyos.[3] she had no more diarrhœa, and went on to a good recovery.

5. *Persistent Vomiting Cured by Magnesia Phos.*[12]—About the first of February I was called to see W. F., a lad about ten years

of age, who had been suffering for some time with vomiting his food. Immediately after eating, sometimes while at the table he will have to go out and throw up, or, as he says, "spit up" what he has eaten. Little or no nausea present. Good appetite, relishes his food and wants to eat often. The mother could ascribe no cause but the probable one that eating much candy, of which he was very fond, during the Christmas holidays, had injured his stomach. On this clue, I prescribed Sulph.[30], which I had found in other cases to be generally sufficient to cure up cases of stomach derangement from eating sweetmeats. In this case, however, it had no effect. I repeated the prescription, and the report was, on—

Feb. 10.—Spits up food immediately after eating; craves sugar. ℞ Arg. nit.[12]

Feb. 14.—Still vomits, also has diarrhœa. ℞ Ars.[12]

Feb. 16.—Diarrhœa better; sour vomiting. ℞ Calc. c.

Feb. 18.—Still vomits. ℞ Phos.[200]

Feb. 21.—Since taking the Phos.[200] the vomiting has ceased. Sac. lac.

Feb. 25.—Vomiting returned. ℞ Phos.[200]

March 1.—Still vomits; aggravation after milk. ℞ Kali c.

March 10.—Still vomits. ℞ Ferrum phos.[12]

March 24.—Spits up food as badly as ever, and has pain in stomach. ℞ Magn. phos.[12]

March 29.—Much improved. ℞ Magn. phos.[12]

He continued on this remedy for a number of weeks, getting well and remaining so.

6. *High Temperature in Typhoid Fever.*—Miss N., æt. 18 years, a school teacher, resident of Ohio, while visiting her brother, living in one of the suburbs of Pittsburgh, was taken sick with what I took to be gastritis, or the gastric fever of the older authors. Under the treatment of her brother, who is a student of homœopathic medicine, and who consulted me in regard to the case, she appeared to do very well, taking Bry. at first; and afterwards, when diarrhœa and nightly restlessness were marked symptoms, Arsen. alb., with very good effect.

Beginning to suspect the case was typhoid fever, I visited her and had my suspicions confirmed. She was, however, getting

along very well. Temperature 103°, pulse 116 in the evening, not much diarrhœa and resting fairly well. A few days after this, on July 30th, I was requested to see her again, as there had been considerable delirium the night before. At 11 A. M. her temperature was $102\frac{3}{5}$°, pulse 120 and slightly dicrotic, patient very nervous Hyos. was prescribed in conjunction with the Arsen. which she was taking. This was at 11 A. M., July 30, temperature $102\frac{3}{5}$°, at 11 A. M. July 31st, twenty-four hours later, the temperature was 109°, pulse 160. She died before it was noon.

THE SPHERE AND UTILITY OF NON-HOMŒOPATHIC EXPEDIENTS IN THE TREATMENT OF DISEASE.

BY DRS. F. R. SCHMUCKER AND S. L. DREIBELBIS, READING.

Presented by the Hahnemannian Medical Society of Reading, Pa.

Practitioners of homœopathy may be divided into three distinct classes, viz:

First—Those who claim that homœopathy is universally applicable to the treatment of disease and the relief of suffering, and that there are no cures effected excepting in accordance with the law of similars.

Second—Those who invariably prescribe drugs homœopathically, but who believe it to be their duty to resort to various adjuvant means of relief, both topical and internal, even though the use of such means cannot be explained homœopathically.

Third—Those who prescribe homœopathic remedies in diseases of children and in mild cases of adults, but who resort to allopathic methods whenever cases become dangerous or severe.

Concerning the first class, it may be said that their enthusiasm in a good cause has had the effect of warping their judgment and deepening their prejudices. There have been and are now in this class, however, many most excellent and conscientious men whose labors in behalf of homœopathy have won for them the merited respect of the homœopathic profession at large.

Of the third class, it can scarcely be said that they can properly

be classed among homœopathic physicians. The practice of habitually giving allopathic prescriptions to the drug store on the part of those practicing homœopathy implies one of two things: Either the practitioner has a very incomplete and superficial knowledge of the homœopathic materia medica; or, having thoroughly studied the same, he has not had sufficient practical experience to trust to the efficacy of potentized drugs prescribed homœopathically, in all cases and under all circumstances. These are they who, in severe cases, tell their patients that homœopathic medicines are not strong enough, and that they must resort to the ponderous doses of the old school.

An infidel under the mantle of orthodoxy is the most dangerous enemy to the truth, and such men should not be permitted to hold seats in the councils of homœopathy. But what concerns us chiefly in this paper is the second class, viz: those who invariably prescribe drugs homœopathically, but who believe it to be their duty to resort to various adjuvant means of relief, both topical and internal, even though the use of such means cannot be explained homœopathically. There appears to be needless anxiety on the part of some physicians concerning the fate of homœopathy, if the use of any non-homœopathic means of relief be encouraged or even allowed. It should be remembered, however, that homœopathy has reference only to the mode or law of administering drugs. This law of *similia similibus curanter* we know by experience to be a fundamental principle, and its truthfulness cannot be affected or compromised by the physician's taking a broad and comprehensive view of the practice of medicine.

There are other means of relief which, while they do not conflict with this law of cure, add greatly to the physician's success in his efforts to administer relief to the sick. Hydropathy and electricity have their excellencies as remedial agents, and within their own peculiar spheres of usefulness should not be despised in practice. And who would say that there are not instances imperatively demanding of the physician the employment of anæsthetics or anodynes, or even cathartics, to say nothing of gargles in sore throats, enemas or suppositories in diseases of the pelvic organs, of antidotes in poisons, of styptics in cases of hæmorrhage, of stimulants in certain cases of extreme prostration. These and

other practical expedients will not affect our confidence in nor conflict with the Hahnemannian method of administering a single remedy at a time in any potency that conscience or experience may dictate, most carefully selected according to symptoms. For homœopathy to despise these means of relief would be like the eye saying to the hand, I have no need of thee, or the head to the feet, I have no need of thee. We would qualify these statements, however, by saying that to the faithful student of homœopathy, non-homœopathic means of relief will be exceptional and but rarely resorted to. The comprehensive scope of drug action, as developed by the provings of Samuel Hahnemann and his faithful disciples after him, has taken the place almost exclusively of anodynes and cathartics.

As to topical applications, we would say that they are often of great advantage in soothing pain, relieving suffering, shortening disease and keeping the confidence of the patient. While these applications may not be curative, they are ofttimes palliative, and may be advantageously employed in connection with the carefully selected homœopathic remedy, which alone can be depended upon to produce a really curative result. Among these local expedients, we may instance the use of iodine, either in the tincture or in solution, topically applied to aid in the reduction of glandular swellings and other tumors; balsam of Peru in pruritis vulvæ, or an ointment of the same drug in fissured nipples; the various kinds of hot poultices in inflammations; heated bran, hop or salt bags in neuralgias or abdominal pains; hot or cold compresses whenever the same may be of service; stimulating lotions judiciously employed in cases of weakened extremities; baths of different degrees of temperature; hot inhalations in spasmodic affections of the air passages; the various kinds of plasters, medicated or otherwise. To these may be added disinfectants, and in surgery the use of antiseptic dressings.

We would remark, however, that while these and other non-homœopathic means of relief may be resorted to as a matter of expediency and of comfort to our patients, both the interest of our patients, as well as the permanency and spread of homœopathy, require that these measures should in no sense be *substituted* for the carefully selected homœopathic medicine.

They are simply practical expedients, which may be employed without interfering in the least with the action of the homœopathic medicine administered internally, the selection of which must be the result of careful study and strict individualization.

A REMARKABLE CASE OF TYPHOID FEVER.

BY J. RICHEY HORNER, M. D., ALLEGHENY CITY.

On the fourteenth of January Dr. Wm. R. Childs prescribed, in his office, for a gentleman, a stranger in the city, who complained of severe pain in the back of his head and neck, dry cough and constipation; in addition to these symptoms a high fever was present. On the seventeenth, the Doctor was called to a hotel and found that his patient had been without attention during the intervening days, and now presented a very aggravated condition. He was suffering from constant nausea and vomiting—the stomach retaining no food—elevation of temperature and acceleration of the pulse. On account of these serious symptoms, he was, on the afternoon of the same day, removed to the Pittsburgh Homœopathic Hospital. From its records the writer, at that time resident physician in the hospital, has compiled the following resumé of the case. It is presented, not on account of its typical character, but because of the alarming hæmorrhages which occurred.

M. J. M., æt. 34, male, unmarried, commercial traveller, admitted January 17th, 1885.

Jan. 17th.—Presents the symptoms detailed above and with these a condition of very great prostration and debility. There is no inclination to eat—seems to be exhausted. Is thirsty, but water will not remain in the stomach; constipation. ℞ Bry.^{1x} every hr.

Jan. 20th.—During the next three days Mr. M. steadily grew worse—delirium at times being present. The temperature ranged about 102° in the morning and 103° in the evening—the pulse corresponding. The bowels have moved but once in the past forty-eight hours. ℞ same.

Jan. 21st.—To-day the bowels began to move and during the twenty-four hours closing at midnight there have been twelve stools. All these were very profuse, offensive, and of a dark brown

color—evidently containing a considerable proportion of blood. They were accompanied with distressing tenesmus, but no actual pain. His general condition had not changed materially, excepting that he shows greater exhaustion. The temperature was $103\frac{1}{5}°$ at 11 A. M., and $101\frac{1}{2}°$ at 9 P. M., the pulse being respectively 108 and 100. ℞ Camphor$^{\theta}$ $\frac{1}{4}$ to 1 hour.

Jan. 23d.—The stools to-day numbered nine, all like those described above. To-day Mr. M. has been quite delirious, at times violently so. He is exceedingly weak, has taken but little nourishment and that very light. The temperature has varied from 102° at 11 A. M. to $98\frac{1}{2}°$ at 10.40 P. M., the pulse for the same time being 108 and 104, weak and small. ℞ Nit. acid^{1x}, every 2 hours.

Jan. 24th.—Bowels moved seven times to-day. The passages were very dark in color, as of clotted blood, offensive and profuse, especially the last of the seven. It was composed of nearly a pint of paste like substance, very offensive, and its voiding was followed by very great debility and exhaustion. Patient has been quite rational to-day, though very restless and sleepless. ℞ continued.

Jan. 25th.—To-day the bowels moved eleven times, the passages being very profuse, offensive and composed of clotted blood. He has very little control over the sphincters, though he is conscious of the bowel movements. General condition not good. He is very much prostrated and at times, is quite delirious. He has taken but little nourishment, the attendant not being able to get him to eat anything. ℞ Nit. acid$^{\theta}$, every hour.

Jan. 27th.—During the interval between midnight of the 25th and noon of to-day Mr. M. has been quite comfortable. He has had but two passages from the bowels, has rested somewhat and taken nourishment. Between twelve and one o'clock this afternoon, however, the bowels moved twice, each passage consisting of a large quantity of blood. This exhausted him very much indeed, the pulse shortly afterward being 130 and the temperature only $97\frac{3}{5}°$. Carbo veg.^{3x} was given at short intervals, also Coca$^{\theta}$ and strong beef tea. Externally, hot applications were made to the body, and under these influences he rallied somewhat towards midnight. ℞ Carbo veg.^{3x}, every hour.

Jan. 28th—To-day he has had three movements of the bowels,

each one profuse and thin, described by his nurse as "blood water." He is a little more easy, does not appear to suffer from any particular pain, though at times he is slightly delirious. He has taken some little nourishment. Treatment continued.

Jan. 29th.—The reaction to-day has been quite marked. The temperature rose to-day to $102\frac{4}{5}°$; the pulse 122. He lies quietly as though completely exhausted. The bowels have moved but once to-day, the passage being small in quantity, brownish and very watery. He has taken some nourishment. Treatment continued.

Jan. 30th.—To-day he has had four stools, consisting of decomposed blood and mucus which was very offensive. He is very drowsy; sleeps nearly all the time. ℞ Rarbo veg.^{6x} every 2 hours.

Feb. 1st.—Has been somewhat better to-day; takes more notice of those around him. The bowels moved but twice, and these stools appeared to approach more nearly to the normal condition.

From this time on Mr. M. progressed as well as could be expected. The most careful attention was paid to his diet and the surroundings. The remedy which gave the most satisfaction during his convalescence was Chin. ars.^{3x}

ŒNANTHE CROCATA IN EPILEPSY.

BY J. RICHEY HORNER, M. D., ALLEGHENY CITY.

Harriet P., æt. 37 years, married, gives a history of an attack of chorea at the age of seven years. This continued to affect her until the menses made their appearance, at which time she dates the commencement of attacks of epileptiform convulsions. These were noticeably aggravated while she was menstruating, but she suffered from them, also, between the cycles.

The following description given me by a companion gives their general character: "She has two kind of fits—one we call a 'funny spell,' and comes on very suddenly. She will jump up and turn over the washstand or chair; once she started towards the stove, and a number of times she has torn her clothes or cut the buttons off her dress. If anyone interferes with her she will fight or become very violent. She will continue in this condition fifteen

minutes or more and then recover her senses and normal condition as quickly as she lost them. She will know nothing of what has occurred. In the other kind, she will suddenly shriek, throw up her hands and fall back unconscious, frothing at the mouth, the eye balls turned up and the limbs and whole body violently jerking and twitching. This will continue for a few minutes and then she will gradually recover. She is very weak after a spell like this, but is not so affected by the other kind."

About the middle of June my attention was called to her case. She had been particularly violent for the preceding two months, the attacks coming on almost daily, and each one worse than its predecessor. I prescribed Œnanthe crocata^{3x}, three times daily. For two weeks no noticeable effect was produced. Then three weeks elapsed and no attacks. In the next two days she had four attacks and during the succeeding two weeks none. She has had in all about ten attacks during the three months she has been taking the remedy. No other measures were adopted.

The uterus is undoubtedly the origin of the trouble, but as yet no examination has been made.

HÆMORRHAGES.

BY THE PHILADELPHIA COUNTY HOMŒOPATHIC MEDICAL SOCIETY.

EPISTAXIS (*Hæmorrhagia narium.*).

The site of this bleeding is the mucous lining of the nasal fossæ, and it is one of the most common varieties of hæmorrhage, due probably to the great vascularity and little support of the blood vessels of the part. It may flow anteriorly, from both nostrils, but as a rule only one is the channel of exit; or posteriorly, constituting what is termed "Choanorrhagia." It is produced by an injury, such as a fall or blow, or is the result of an operation, or due to local congestion, brought about by running, coughing and blowing the nose too hard, especially when there is a predisposition to it; or depend upon passive congestion, with disease of the heart or lungs; or upon a medullary growth within the nose; or arise from an impoverished state of the blood, as in scurvy, purpura and anæmia. Frequently it is supplementary to the menses, when it is

called vicarious, and even an essential variety is admitted, which occurs spontaneously and is ascribed to the hæmorrhagic diathesis. (Hæmophilia.)

According to Espanet of France, it is often one of the first manifestations of the hæmorrhoidal constitution, and later in years it is usually replaced by hæmorrhoids. There are cases on record in which the blood, after passing posteriorly into the larynx and stomach, has been coughed up or vomited back, giving rise to the belief that the bleeding was of pulmonary or gastric origin.

As a concomitant, epistaxis is sometimes observed in acute pneumonia, either as an early symptom or among the phenomena of the crisis. It is seen in chlorosis, and especially in that variety of anæmia known as Grave's disease. In purpura hæmorrhagica it constitutes the most common bleeding from the free surfaces. We may find it as a precursory symptom of fatal cerebral hæmorrhages. It is a frequent attendant of severe attacks of whooping cough, and whilst it shows how great is the interference with the circulation, it often becomes a valuable remedy. In measles it, occurs as a complication, and in rare cases may be so great as to endanger life. Finally, bleeding from the nose has also been noticed in dengue, diphtheria, erysipelas, influenza, relapsing fever, scarlatina, variola maligna and yellow fever.

An attack of nasal hæmorrhage may occur without any prodromic symptoms, or be preceded by a heaviness of the head (more or less marked), a tickling which provokes rubbing of the nose and sneezing, or by congestive cephalic phenomena, such as heat and redness of the face, injected eyes, violent beating of the temporal and carotid arteries, frontal headache, buzzing in the ears, blurring of the sight, dilated pupils, photophobia, vertigo and a full, quick, bounding pulse.

The period of life most common for its occurrence is puberty, but no age is exempt from it. Dr. Preston, in an article on nervous hæmorrhages, which he wrote some years ago, asserts that "epistaxis forms the most common hæmorrhage of childhood, and that in a great proportion of cases it is simply and perfectly harmless. When it is dependent upon active congestion it is usually arterial, and proves its own remedy; when it is the result of mechanical congestion, or forms one of the developments of the

hæmorrhagic diathesis, it is passive and probably venous."

The amount of blood lost varies from 100 to 200 grammes. In certain individuals it recurs frequently, especially in summer, and the flow may be so profuse as to produce syncope. In those who suffer from hæmophilia it may prove fatal in spite of treatment.

The local treatment consists: First, in the removal of the cause, such as foreign bodies, fragments of denuded or dead bones, etc., or in the restoration and retention of displaced parts in their normal position (in cases of injury). Second, in diminishing the flow of blood by means of a convenient posture of the body, the recumbent being held by some the best. (The flow of blood has been arrested by directing the patient to stand up with the head elevated, compressing the nostril whence the blood flows with the fingers, raising the corresponding arm perpendicularly, and holding it in this position for about two minutes.) Third, in the dashing of cold water on the face, or its injection into the nostrils, or the injection of styptic cold solutions, in laying a bag of ice on the forehead, or in snuffing up powdered astringents (matico or gall-nuts) into the nose. Monsel's solution on pledgets of cotton carried up to the bleeding spots has been used with success, and if in special cases these means fail, we can resort to the platinum wire loops of the galvano-cautery; and, fourth, in compression, either on the facial artery, where it reaches the alæ, or in the carotid, or by plugging, anteriorly or posteriorly, as the case may be.

The plugging of the posterior nares is best effected by passing a Bellocq's canula along the floor of the nose, with the piston drawn out, and after the curved point has projected below the soft palate, to push forward the piston which carries the eyelet into the cavity of the mouth, then thread it and draw out the piston conveying the twine, and in this manner we have got a string passing along the floor of the nose, through the posterior nares, looped round the soft palate and emerging at the mouth. A roll of lint or a piece of sponge, somewhat larger than the opening of the nares, is next attached to the lower part of the cord, twelve or fifteen inches from its extremity, and by gently pulling the upper or nasal part the plug is drawn into the mouth, behind the soft

palate and into the posterior nares. The ends of the string should then be secured for withdrawal and the plug allowed to remain a day or two, as required. Bear in mind that "the long retention of the plug in position is followed by great fetor and the free formation of muco-pus, conditions which tend to debilitate the patient." If both nostrils are to be plugged, repeat the operation, and if the anterior and posterior nares, pass a double string, and after attaching the rolls of lint conveniently draw them in opposite directions.

INTERNAL TREATMENT.

Aconite.—This is a valuable remedy, if the approach of the bleeding is attended by marked anxiety and restlessness, indicating that the circulation and nervous system are greatly disturbed, or if such condition should supervene during the attack, especially in young and plethoric individuals. It precedes Bryonia or Nux vom. if the bleeding recurs at the least stimulating or heating cause, for instance, wine.

Amm. carb.—If the epistaxis appears every morning on washing the face, after repeated sneezing, or after dinner, especially if after the flow has ceased a bloody mucus is frequently blown from the nose.

Argent. met.—If preceded by a tickling, crawling sensation in the nose, occurs after dinner, or if the bleeding starts at the least effort, as blowing the nose (Rhus tox).

Arnica.—Nose-bleed from mechanical causes, as blows or falls, copious on every exertion, preceded by tingling, frequently with bruised pain and repeated sneezing (Amm. c.); in the morning (Carb. v., China, Bryon.); after washing the face (Amm. c.); caused by cough, with bloodshot eyes. The blood is bright, red or mixed with clots.

Belladonna.—If the patient shows signs of cephalic congestion, such as heat and redness of face, frontal headache, tingling in the nose (Arn.); beating of carotids, dilated pupils, vertigo, obscuration of sight or buzzing in the ears (China, Nux v.), especially if the blood is bright, red and hot, flows freely, even from both nostrils. The bleeding appears during the night, surprises during sleep, awakens and returns sometimes in the morning.

Bryonia.—For vicarious bleeding I do not know a better rem-

edy. It is also indicated if the epistaxis is due to a general state of vascular erethism or congestion; the blood is bright red, occurs principally in the morning as soon as patient moves about; about 3 A. M. (Sulph. 3 P. M.), or at night during sleep, or after being under the rays of an ardent sun.

Calc. ost.—When the blood flows from the right nostril, especially in the morning, with obstructed nose, with disturbed menstruation or fainting spells. Also in scrofulous children, if the bleeding is frequently repeated and without any apparent cause.

Carbo ani.—When the bleeding takes place every morning and is preceded by a dull feeling in the head or by vertigo.

Carbo veg.—At night, in the morning, or in bed, especially if before and after every attack the face becomes pale and pulse small, intermittent. Every morning a few drops of blood flow from the nose, but during the rest of the day the bleeding is very profuse and long lasting, repeated several times daily for weeks, and provoked by the least movement. But worst of all, at night or in the forenoon, when it is followed by pain over the chest. Also, after debauch (Nux v.), in old debilitated people (Sec.), and while straining at stool (Coffea).

China.—In habitual nose-bleed, especially if it occurs in the morning from 6 to 7 o'clock, and is very often renewed. It is principally indicated when repeated losses of blood have left the patient in a weak, anæmic condition (Ferr.), with humming in the ears, pale face and fainting spells (Calc.)

Cina.—Indicated when the bleeding from the nose occurs in children who suffer with worms (Merc., Spig.)

Crocus sat.—Is the remedy for women who menstruate profusely and long and are subject to fainting at the approach of the menses. At the moment of the attack, the forehead becomes bathed with a cold perspiration (Verat. alb.). The blood is black, thick and glutinous and hangs from the nose in long strings (Merc.). Periodicity and chronicity are characteristic.

Dulcamara.—If the blood is hot and clear, with pressure above the nose, or when it occurs immediately after getting the feet wet.

Erigeron.—When attended by fever, rush of blood to the head and red face. (*Erecthites*, like *Erigeron*, is indicated when the pri-

mary hæmorrhages are attended by excitement of the circulation and the blood is of a bright-red color.)

Ferrum.—Is the remedy, either for a profuse, repeated bleeding, through one nostril only, or when both nostrils are continually filled with clotted blood, especially in anæmic persons, subject to ebullitions, with an ashy pale face, flushing easily—a kind of pseudo-plethora, who are always cold, even while in bed; emaciated and weak, from continuous losses (China). The blood is light or lumpy, coagulates easily (Merc., Puls.).

Graphites.—When preceded by rush of blood to the head and heat of the face, frequently repeated, in the evening, at night or in the morning, with running coryza, especially in women whose menses are too scanty and too pale, or too late (Puls.), with violent colics.

Hamamelis.—Indicated in vicarious bleeding from the nose, especially in young anæmic girls (Puls.), or when there is hæmoptysis at the same time, due also to a suppression of the menses. The blood is dark, venous; flows slowly, and does not coagulate. The mind is calm, and fulness in the head may be present.

Hydrastis.—If the bleeding is attended by burning rawness and is followed by itching, especially through the left nostril (Rhod.).

Ipecacuanha.—If the bleeding occurs in the course of a continuous or intermittent fever or during whooping-cough (Mur. acid). Also for a profuse epistaxis, of bright red blood, especially if preceded or attended by nausea, or if the face becomes pale, bloated, with blue margins around the sunken eyes.

Kali bich.—I gave this remedy with good success in a case of nose bleed with dry coryza, preceded by pressure and tightness at the root of the nose, and where the blood was thick and of a dark red color. I was led to its use by a persistent tickling high up in the left nostril.

Kali Carb.—In periodical nose bleed, occurring every morning at 9 o'clock, or when washing the face, as in Amm. c. Also after great loss of blood. (China.)

Mercurius.—When the bleeding is preceded by pressure around the head, as from a band, and the blood coagulates so quickly that it hangs in long dark strings from the nostrils (Croc.). It may

occur on coughing (Rhus); during sleep (Bryo., Nux v.); or in children complaining of worms (Cina, Spig.).

Millefolium.—In arterial bleeding, flowing without apparent cause. Also when the blood is dark, and from upper part of the nose to eradicate predisposition. Profuse nose bleed in congestions to the chest and head.

Nux Vom.—When preceded or accompanied by frontal headache, red cheeks ond other signs of cephalic eongestion especially in young persons, and if it occurs in the morning. Also during sleep (Bryo., Merc., Verat. alb.); or from suppressed hæmorrhoidal flow, in those advanced in years. At any age; after too high living; abuse of coffee; and alcoholic drinks. Debauchers who are irritable and thin. The blood is usually dark.

Pulsatilla.—Is the remedy for young and anæmic females, whose menses are late, scanty, or temporarily suppressed, with a mild and tearful disposition; especially if the epistaxis appears every month, a short time before the arrival of the menses; or if it occurs between noon and midnight. Also indicated in nose bleed with dry coryza. It resembles *Hamamelis*, but a difference is found in the mental condition and in the character of the blood. Both have dark, venous blood, but in the former it is easily coagulated, while in the latter it is non-coagulable.

Rhus tox.—Is indicated when the bleeding is due to some violent effort, as lifting heavy weights, coughing hard, straining at stool (Carb. v., Phos.), &c., especially if the blood is of a bright red color and coagulates quickly. It is more profuse at night, takes place in the morning, and recurs on blowing the nose (Lach.), or on stooping (Bryon., Nux m.).

Secale cor.—When the blood flows continually, is of a dark color and thin (Crotal., Nit. ac.), with great prostration and a small, thready pulse, due to previous hemorrhages. Either in old, decrepit persons and drunkards (Nux v.), or in young, feeble, cachectic women.

Sepia.—If the bleeding occurs during pregnancy, or childbed, or in women suffering from uterine disorders in whom the menses have been absent for some time; especially if brought about by a fall or blow on the nose (Arn.) and frequently recurring at the least touch of the nose.

Sulphur.—When the epistaxis occurs at 3 P. M. (3 A. M. Bryo.) with vertigo, and is followed by great soreness of nose to touch; especially if it returns on blowing the nose (Rhus, Lach., Spong.). It is a good remedy against the disposition to nose bleed.

Verat. alb.—Is indicated in the worst conditions, when the face is deathly pale, the body cold and the pulse slow, or intermittent. The blood is black, viscid and tenacious. Right side bleeding, only at night in sleep.

REPERTORY.

Blood, black and thick:—Croc., Merc., Nux v., Puls.
" " *thin:*—Crot., Ham., Nit. ac., Sec., Sulph. ac.
" " *tenacious:*—Croc., Merc., Sec., Verat. alb.
dark and non-coagulable:—Ham., Laches.
" " *easily coagulating:*—Croc., Merc., Puls., Rhus.
light and easily coagulating:—Ferr.
clotted:—Arn., Bell., Cham., Croc., Ferr., Ipec., Merc., Nit. ac., Nux v., Puls., Rhus., Stram.
pale:—Lach. (profuse)., Led. (long lasting).
" *and thin:*—Carb. v., Ferr., Graph., Puls., Sulph.
dark:—Croc., Ham., Kali b., Mill., Nux v., Puls., Ver. alb.
bright red:—Acon., Arn., Bell., Bryo., Erecthites, Erig., Ipec., Mill., Rhus.
hot and red:—Bell.
hot and clear:—Dulc.
Bleeding, profuse and lasting:—Croc., Carb. v., Ferr., Mill., Mur. ac. Phos., Trill.
frequent and easy:—Carb. v. (Baryt. c.).
copious, after every exertion:—Arn.
slight, relieving headache:—Petrol.
profuse, soon ceasing:—Cactus.
scanty:—Calad., Clem., Ferr., Lach., Nat. ars., Spong., Sulph., Sulph. ac.
long lasting:—Led., Mur. ac.
continuously running:—Sec. (passive).
violent:—Acon., Arn., Arg. m., Carbo v., China, Croc., Ham., Kali j., Tereb., Trill., Sepia, Spig.
vicarious:—Bryo., Laches., Puls. (Ham).

Bleeding through r. nostril:—Calc. c., Cup., Magn. c., Verat. alb.
" *l. nostril:*—Amm. m., Hydras., Kali b., Rhod., Tarax. (Rhus glab.).
" *both nostrils (with congestion):*—Bell.
habitual, especially in the morning on rising:—China.
periodical:—Carbo v., Kali c.
in young plethoric people:—Acon., Nux v.
in young girls, with amenorrhœa:—Bry., Ham., Puls.
in scrofulous children:—Cal. c., Sil.
in children with worms:—Cina., Merc., Spig.
in old people:—Ferr. phos., Sec. (Carbo v).
anœmic patients:—China, Bry., Ferr., Hyd., Kali c., Puls.
in debilitated individuals:—Carbo v., China, Sec., Verat. alb.
in drunkards:—Hyos., Nux v., Sec.
in the morning:—Amm. c., Arn., Bry., Calc. c., Canth., Caps., Carbo v., China, Lach., Nit. ac., Nux v., Rhus, Sulph.
in the afternoon:—Calc. ph., Graph., Puls.
in the evening:—Ant. c., Ferr., Phos., Puls., Sulph. ac., Sulph.
at night:—Bell., Carbo v., Graph., Rhus, Verat. alb.
in bed:—Aloes, Caps., Carbo v.
while sleeping:—Bell., Bry., Nux v., Merc., Puls., Verat. alb.
every morning on washing the face:—Amm. c., Kali c.
" " *after* " " " —Arn.
" " *at the same hour:*—Carbo v.
" *month before menses:*—Puls.
between noon and midnight:—Puls.
after dinner:—Amm. c., Arg. nit.
repeated several times daily, for weeks:—Carbo v.
at 8 A. M.:—Bryon.
" *6 to 7 A.M.:*—China.
" *9 A. M.:*—Kali c. (periodical).
" *3 P. M.:*—Sulph.
on blowing the nose:—Arg. m., Lach., Rhus, Spong., Sulph.
" *coughing:*—Merc., Nat. m., (at night).—Rhus.
" *sneezing:*—Arn., Rumex, Sabad.
" *stooping:*—Bry., Carbo v., Nat. m., Nux m., Rhus.
while straining at stool:—Coffea, Carbo v., Phos., Rhus.

Bleeding while blowing on instruments :—Rhus.
at any bodily effort :—Rhus.
" *least stimulating or heating cause :*—Acon., Bry., Nux v.
provoked by the least movement :—Carbo v., Rhus.
recurring after wine :—Acon., Nux v.
removing confusion of the head :—Cham.
stops and returns often (during menses) :—Nat. sulph.
in girls who grow too rapidly :—Phos. acid.
as soon as patient moves about, after rising A. M.:—Bry.
preceded by tickling in the nose :—Arg. m., Carbo v., Laches., Bell., Rhus. (Kali b. high up).
" *by tingling :*—Arn., Bell., Rhus.
" *by crawling :*—Arg. m., Carbo v.
" *by itching :*—Amm. m.
" *by sneezing :*—Amm. c., Arn., Coni., Sabad.
" *by pressure above the nose :*—Bry., Dulc., Kali b., Ruta.
" *by dullness of head :*—Carbo a.
" *by pressure around the head :*—Merc.
" *by headache and throbbing :*—Bell., Nux v.
" *by headache and red cheeks :*—Nux v.
" *by hammering headache and flushed face :*—Ferr.
" *by ebullitions and flushings :*—Ferr.
" *by cephalic congestion :*—Acon., Bell., China., Croc., Coni., Graph., Nux v.
" *by piercing pain from eyes to root of nose :*—Millef.
" *by buzzing in the ears :*—Bell., China, Nux v.
" *by vertigo :*—Bell., Carbo a., Nux v.
" *by nausea :*—Ipec., Nux v.
after debauch :—Carbo v., Nux v.
" *stimulants :*—Acon., Bell., Bry., Nux v.
" *the abuse of coffee :*—Nux v.
" *being in the rays of the hot sun :*—Bry. (Acon.).
" *being over-heated :*—Acon., Bry., Thuj.
" *a fit of passion :*—Ars.
" *crying :*—Nit. ac.
" *sneezing :*—Amm. c. (repeated)., Coni.
" *vomiting :*—Ars.
" *headache :*—Ant. c.

Bleeding after singing :—Hep., Rhus.
" *bodily efforts :*—Arn., Bry., Carbo v., Rhus, Sulph.
" *fatigue :*—Carbo v., China, Ferr., Sec.
" *lifting heavy weights :*—Rhus.
" *a blow, etc.:*—Arn., Elaps, Sepia (fall on nose).
" *getting the feet wet :*—Dulc., Rhus.
with dry coryza :—Kali b., Puls.
" *running coryza :*—Graph.
" *loss of smell :*—Ipec.
" *obstructed nose :*—Ars., Calc. c., Puls.
" *frequent sneezing :*—Arn. (Amm. c.).
" *violent sneezing :*—Rumex, Sabad.
" *painful nostrils :*—Rumex.
" *burning rawness of nose :*—Hydras.
" *cold tip of nose :*—Lobel., (Carbo v.).
" *heaviness of head :*—Coffea, Kreos.
" *headache :*—Bell., Bry., Carbo a., Dulc., Kreos., Nux v.
" *vertigo :*—Bell., Bov., Carbo a., Sulph.
" *heaviness and throbbing in forehead :*—Kreos.
" *hot head and cold body :*—Arn.
" *beating carotids and dilated pupils :*—Bell.
" *congestion of the head :*—Acon., Bell., Bry., China, Erig., Ferr., Graph., Nux v.
" *vascular erethism :*—Acon., Bry.
" *anxiety and restlessness :*—Acon.
" *fear of death :*—Acon., Ars.
" *fever :*—Erig.
" *hard breathing :*—Acon., Bell., Bry., Carbo v., Ipec., Phos., Puls., Spong., Sulph.
" *fainting spells :*—Calc c., China, Croc.
" *cough and bloodshot eyes :*—Arn.
" *dry cough :*—Indigo., (Bell.).
" *nausea :*—Ipec., Verat. alb.
" *red face :*—Bell., Erig., Nux v., (Ferr. flushed face).
" *very pale face :*—Carbo v., China., Ferr., Ipec., Puls., Verat. alb.
" *cold sweat :*—Croc., Verat. alb.
" *cold sweat and small pulse :*—Verat. alb.

Bleeding with great prostration :—Ars., China, Ferr., Verat. alb.
" *great prostration and drawn features :*—Sec.
" *ebullition and anæmia :*—Ferr.
" *humming in the ears :*—Bell., China, Graph., Nux v.
" *pressure at root of nose :*—Dulc., Ruta.
" *spasmodic movements :*—Mosch.
" *salivation :*—Hyos.
" *relief of chest and eye symptoms :*—Brom.
" *violent burning of nose :*—Led.
" *hæmoptysis at the same time :*—Ham.
" *disturbed menses :*—Bry., Calc. o., Croc., Lach., Nux v., Puls., Sabin., Sec., Sep., etc.
" *amenorrhœa :*—Bry., Ham., Lach., Puls., Sep. (Phos.).
" *scanty menses :*—Bry., Graph., Puls., Sec., Sep., etc.
" *profuse menses :*—Acon., Calc. c., Croc., Sabin,, etc.
" *late, long-lasting and profuse menses :*—Ferr.
" *scanty, short menses, or intermittent flow :*—Puls.
during pregnancy :—Cocc., Sep.
" *child bed :*—Sep.
" *continuous or intermittent fever :*—Ipec.
" *typhus or typhoid fever :*—Crotal., Laches. (Bry.)
" " " *with some relief :*—Rhus.
" " " *with no relief :*—Phos. ac.
" *diphtheria :*—Crotal., Phos. (profuse).
" *whooping cough :*—Cina, Dros., Mur. ac., Stram. (Ipec.).
" *measles :*—Puls., Sabad., (Bry. with late rash).
" *endocarditis :*—Cactus, Spig.
" *catarrh :*—Kali b., Ipec.
" *ulcerative ozæna :*—Sang.
" *suppressed hæmorrhoidal flow :*—Nux v., Sulph.
" *climaxis :*—Bell., Bry., Ham., Lach., Nux v., Puls., Sep., Sulph. ac., Sulph.
" *menses. stopping and returning often :*—Nat. sulph.
followed by fluent coryza, with sneezing :—Ant. tart.
" *by itching :*—Hydras.
" *by soreness, in upper nose :*—Led.
" *by soreness, on touch :*—Sulph.
" *by pain over the chest :*—Carbo v.

EDUARDO FORNIAS, M. D.

HÆMOPTYSIS.

(HÆMORRHAGIA PULMONIS.)

This is a term usually applied to any hæmorrhage proceeding from the bronchial vessels (bronchial hæmoptysis), or from the pulmonary vessels (pulmonary hæmoptysis), but literally it means *spitting of blood* (from *ema*, blood and *ptysis*, to spit,) without reference to the sources of the bleeding.

Ulceration of the larynx, trachea and bronchi may produce hæmoptysis, but such a lesion in the lungs, causing effusion into the air-cells and into the interalveolar and interlobular tissues, is the most common source of the trouble. It may also be due to traumatism, straining, irritant inhalations, pulmonary apoplexy, embolic pneumonia, hæmophilia, hydatids, cardiac troubles, rupture of aneurisms, vicarious menstruations, and it can occur idiopathically, but in a great majority of instances it is of phthisical origin.

Fragility of the vessels and catarrhal tendency are, according to Dr. Carson, not only the two elements of heredity, but also the factors of the acquired predisposition.

The Vienna Hospital reports, running through more than fifteen years and embracing more than 20,000 cases, give as the ages most liable to hæmoptysis those between 18 and 29 years. No statistics as to sex are given.

The symptoms vary with the cause and amount of the bleeding, but usually those preceding the attack are heat and oppression in chest, laborious breathing, trickling sensation behind the sternum, excited action of the heart, dry, titillating cough and sweetish or salty taste. It can also occur without warning, especially if profuse, or without symptoms, if scanty.

The blood, as a rule, is of a bright red color and frothy, but this last characteristic is absent if it is expelled rapidly, or it may lose its florid color and spumous appearance when it is retained for some time in a vomica or dilated bronchus, then giving rise to the belief that it is of gastric origin, as the patient is often scarcely able to tell us whether he vomited or coughed it up. Carson says that "there is sufficient inconstancy in color to prevent its being reliable in distinguishing the special source of the bleeding, though usually the bright color is of bronchial and the dark of pulmonary

origin. If bright red at the onset, it loses some, if not the whole, of its brightness as the attack progresses or is subsiding, sometimes because of retention in the air-passages." Again, pulmonary or bronchial blood may reach the mouth without actual cough and then be spit out, or it may be swallowed and then vomited, or discharged by the bowels, losing entirely its distinctive features, and in such cases we have to depend for diagnosis on the general signs of the disease and on the physical examination of the lungs and heart.

When the hæmorrhage is abundant, the patient becomes pale, anxious, tremulous and fainty, but such results are often due to the shock and not to the loss of blood. If a large vessel has been divided, the first hæmorrhage may cause fatal syncope. The appearance of shock, increased dyspnœa, a large amount of blood, excited action of the heart and increased new areas of dulness or râles at certain parts of the lung other than the usual sites of phthisical disease should be watched with solicitude.

Spitting of blood is naturally a constant source of alarm to the patient, who believes it always of tubercular origin, when it is so that the bleeding can come from parts connected with the nose, mouth, throat and œsophagus, arising from ulceration, cancer, aneurism, a varicose condition of the œsophageal veins, etc.; hence the necessity of an accurate diagnosis.

"I have met," says Bennett, of England, "with several cases where supposed pulmonary hæmorrhages really originated in follicular disease of the pharynx and larynx, and, with the supposed phthisical symptoms, was removed by the use of the probang and nitrate of silver solution."

The ejection of blood from the lungs, though, whether in small or large quantities, demands our most solicitous consideration, for whilst in some cases it is a symptom free from danger, in others it is an indication of serious, if not of fatal, disease.

In regard to the diagnosis of hæmoptysis, bleeding from the stomach is the one that obviously claims comparison, as the blood in both troubles has the same channel of exit, and although in exceptional cases the signs are misleading, still the quality and appearance of the blood, its admixtures, the manner of its ejection and the accompaniments are important, deciding factors.

The principal contrasting signs of these hæmorrhages are:

From the Lungs.	*From the Stomach.*
Dyspnœa.	Nausea.
Blood coughed up.	Blood vomited.
Blood florid, sometimes frothy.	Blood dark, not frothy.
Blood mixed with sputa.	Blood mixed with food.

The fact that blood from the nose is sometimes swallowed and afterward ejected by vomiting should be borne in mind.

"Hæmoptysis, followed by a persistent cough, and still more if cough preceded its occurrence, is always presumptive evidence of a phthisical affection. Occurring without having been preceded by cough, and when cough does not immediately follow, should suggest the probability of phthisis. In the large proportion of cases under these circumstances it is a forerunner of the diagnostic symptoms and signs of the disease." (Flint.)

"The physical signs of a slight hæmorrhage from the lungs are very obscure. No information as to the seat or amount of the hæmorrhage is furnished by inspection, palpation or percussion. Auscultation may, however, indicate the spot at which the hæmorrhage occurs, by the presence of moist râles. If the hæmorrhage is profuse and accompanied by pulmonary apoplexy, abundant moist râles will be heard at the seat of the effusion, and they remain audible until coagulation takes place or the effusion is removed. When pulmonary apoplexy occurs, it is usually found in the lower and posterior portions of the lungs. If the nodules are few and small, there will be no positive physical evidences of their situation. When the nodules are large and lie superficially, percussion will give more or less dulness over a limited space corresponding to the extent of the hæmorrhage, and on auscultation there will be a diminution or absence of the respiratory murmur. When the extravasation is situated near a large-sized bronchial tube, bronchial breathing and increased vocal resonance are heard, and there is also increase in the vocal fremitus." (Loomis.)

In cardiac hæmoptysis, the symptoms and physical signs of valvular, usually mitral, disease in a considerable degree of advancement will exclude phthisical disease.

The prognosis of hæmoptysis, especially of phthisical origin, is not governed by the amount of blood ejected. A small

repeated bleeding may have more significance than an occasional large one, and *vice versa*, and as Dr. Carson so well asserts, "the family and personal equation is of more importance than the mere quantity." "We may have a slight hæmoptysis and a large increase of the morbid condition following it, and the reverse, the result depending on the individual tolerance of and susceptibility to reaction." "As in the second stage the reactive elements are more potent, the small hemorrhages then are less beneficial. They are the index of activity in the destructive lesions, and yet may relieve the accompanying congestion. The easiest appreciable symptom of the progress of the disease is the fever. We may fail to properly interpret physical signs because of want of familiarity with the individual case before us. If besides more fever there be more cough, dyspnœa and debility, the prognosis increases in gravity. These remarks will apply with more force to the large hæmorrhages than to the smaller ones, and are the guides for prognosis in all the clinical forms of hæmoptysis."

A profuse hæmorrhage, then, is sometimes a grave event, and may prove the immediate cause of death, especially if cavernous, but the bronchorrhagia prior to the formation of cavities is not infrequently followed by a sensation of relief, and as Flint says, the analytical study of a large collection of cases shows that the occurrence of bronchial hæmorrhage does not diminish, but apparently increases, the chances of arrest and tolerance of the disease. This statement, holds the same authority, is true with regard to cases in which the hæmorrhage is often repeated and profuse, as well as to those in which it is slight and infrequent.

Jaccoud, of Paris, also asserts that during the initial stage of phthisis, when the danger rests particularly on the congestive condition which provokes the extension of the lesions, the hæmorrhages can become really critical, and dispel, for a more or less length of time, a threatening inflammation. In such cases, far from being a bad sign, it is on the contrary a salutary phenomenon.

If all this is true, we can well afford to allay the usual apprehensions of the patient by assuring him that the hæmorrhage will be more of a security than a danger, because it is the expression of a local congestion that will be relieved by the discharge.

The accessory treatment consists principally of rest in a cool

room, moderate in the milder forms of the trouble, absolute in the graver ones. Quiet surroundings and the avoidance of all emotions are essential. The patient is to receive all possible encouragement and to reach this effectually we should behave with perfect calmness and unconcern. Cold drinks, ice to the chest and nucha, and stimulating foot-baths are often serviceable. Astringents or styptics have been discarded as useless, even by old school physicians, but the inhalations of the vapor of the oil of turpentine (place a small quantity in an earthen dish floated on hot water) have been recommended as valuable, especially for prolonged spitting of blood in small quantities for days or weeks.

INTERNAL TREATMENT.

ACALYPHA IND.—In obstinate cases of arterial hæmorrhage, preceded by burning in the chest and accompanied by emaciation, slow fever and small depressed pulse. **The blood is pure bright red* (Acon., Dulc., Rhus.) in the morning, or *dark, clotted* (Arn., Puls.) in the evening. Spitting of blood, brought on by a violent dry cough (Dig., Rhus.).

Note;—Dr. Tonnere, of Calcutta, was the first to notice this violent, dry cough, followed by spitting of blood after the administration of *Acalypha* , and since then, it has been used with good results.

ACONITE.—When the attack is preceded or accompanied by *symptoms of congestion*, such as fulness, burning pain (Bell.), palpitation, and a sensation as if the blood was boiling in the chest and followed by burning feeling under the sternum. *The mental condition and nervous restlessness* furnish additional indications. **The blood is arterial* (*hot, red and frothy*), *and the least cough brings on a discharge* (Mill.). The recumbent posture brings relief. It is the remedy for plethoric persons who drink much wine, or for pregnant women, with nocturnal anguish, lamentations and bright red face.

ARNICA.—In those subjected to unusual strain and fatigue, who preternaturally develop their muscular system, as soldiers, miners, and professional athletes. *After a fall or blow* (Ruta). **The blood may be profuse, dark and clotted* (Puls., Ham.), coming with little effort, or it is *bright red, frothy* (Acon., Mill.), mixed with mucus (Bell., Opi.) A burning and constriction of chest. Tickling cough

under the sternum; laborious breathing and contusive pain in the head, chest and back, when coughing, are additional indications.

BELLADONNA.—Is the remedy for the young and robust, who suffer from congestion of blood to head or chest, or both. **The bloody expectoration is mixed with mucus* (Arn., Opi.), and occurs principally in the morning (Phos., China, Nux v.), leaving a bloody taste (Ipecac., China). Attacks of coughing, from tickling in the throat (Arn., Nux v.), bring it on. Especially indicated when there is a *flushed face* (Acon., Opi., Nux v.), *throbbing headache*, *pulsating carotids*, *sparks before the eyes*, *stitches in apex of right lung and a sensation as if chest were filled with blood.* If with these last symptoms there should be a discharge of *bright red blood*, *imparting a sense of heat*, BELLADONNA is also the remedy.

CACTUS.—When due to functional disorders of the heart, *with marked arterial excitement*, convulsive cough, profuse bleeding and *a sensation of constriction in the heart, as if an iron hand prevented its normal movements*, as if squeezed together (Iod., Arn., Kali c.). Especially indicated if the congestion to the chest hinders patient from lying down in bed (Acon.).

CHINA.—*After venesection* (Ferr., Ipec., Senecio) or other losses of animal fluids (Ars.), *with ringing in the ears*, *fainting spells*, *debilitating sweats* and *constant desire to lie down* (Ferr.). Brought on by a *dry* (Hyos., Ferr., Arn.), *violent*, *racking cough* (Ipec., Nux v.), or when the blood comes without cough, as if vomited up (Arn., Ferr., Ipec., Phos.); worse after exercise (Bell., Bryo., Ferr.). When it occurs principally in the morning (Bell., Nux v., Phos.). **The blood is bright-red* (Acon., Arn., Bell., Dulc., Ferr., Ipec., Millef.); there is a good deal of *hoarseness* (Phos., Sulph.), *pain between the scapulæ* (Ars., Ferr.), *pallor of the face* (Ars., Carbo v., Ferr., Puls.), *coldness of the skin and extremities* (Ars., Carbo v.), *dimness of vision*, *great debility* (Ars., Ferr.) and *a taste of blood in the mouth* (Bell., Ipec.). Such are the leading symptoms for China.

DULCAMARA.—In consumptive and scrofulous patients, sensitive to changes of temperature, with stitches, here and there, in the chest. **The blood is bright-red* (Acon., China, Ferr., Ipec.), and *there is a constant tickling*, *with desire to cough* (Bell.). The attack is provoked by a cold or a loose, protracted cough, and is worse during repose (Rhus tox).

FERRUM.—Like *China* indicated after venesection (Ipec., Senec.). Both have *bright-red blood*, but in *Ferrum* the *bleeding is scanty*. In both *a dry cough brings on the blood*, but the *cough of Ferrum is slight*, while that of *China is violent*. Both have *pallor of face* (Ars.), but the *Ferrum* patient *flushes easily*. Both have *great weakness, which necessitates lying down*, but in *Ferrum moving about slowly always gives relief*. Both have *interscapular pain*. Both have *aggravation after exercise*. But *Ferrum* has marked *heavy breathing* (Ipec.), *unrefreshing sleep, frequent palpitations, great fatigue after talking* (Phos.), and *the attack* is more violent at night (Puls., Rhus., Hyos.).

HAMAMELIS.—*When there is a tickling cough* (Arn., Bell., Nux v.), *with taste of blood* (Bell., China., Ipec.), *or of sulphur*. Dull, frontal headache, tightness of chest (Phos.); inability to lie down, on account of hard breathing, from congestion; *fulness in the head* and *tranquility of mind*. **The blood is venous, raised with little effort* (Ipec.), like a simple, warm current, established from within outwards.

HYOSCYAMUS.—*In persons addicted to spirituous liquors* (Ars., Nux v., Opi.). Especially when the attack is preceded by a dry cough (China, Ferr., Arn.), more violent at night (Ferr., Puls., Rhus, Sec.), and accompanied by spasm. **The blood is bright-red* (as in Ferr., Ipec. and China), mixed with coagula. Long talking exhausts the patient (Ferr.).

IPECACUANHA.—Is one of our most useful remedies in hæmorrhages from the lungs. Like *China* and *Ferrum* (with which it has many points of resemblance), it is indicated aftrr *venesection*, especially if the *bleeding is scanty*, constituting *an expectoration of blood-streaked mucus, or a blood-spitting, from the least effort, without cough*, and *as if vomited up* (Arn., China, Ferr., Phos.). It is also the remedy when the hæmorrhage is **profuse, of a bright-red color* (Acon., Arn., Bell., China, Dulc., Ferr., Rhus), provoked by a *dry, tickling, racking cough* (China, Nux v.), or even by *a little hawking* (Acon., Ham., Nux v.), worse *from the least exertion* (Bell., China, Ferr.), preceded by a *sense of bubbling in the chest* and accompanied by *nausea*, chills, *heavy breathing, oppression* (Phos.), livid face (Opi.), small and frequent pulse, *anxiety* (Acon.), *debility* (China), patient cannot utter a word (Ferr., Phos.), and *a protracted*

taste of blood in the mouth (Bell., China, Ham.). Likewise indicated when the menses are disturbed, or the bleeding occurs at the menstrual period (Puls., Phos., Verat. alb.). Jahr even recommends it after mechanical injuries, and Chargé after exposure to cold and rain.

LEDUM PAL.—Indicated in *rheumatic* or *gouty individuals*, who are weak from the abuse of *Colchicum*, or in *pale, delicate women, who are always cold* (Puls., Sep.), especially if they complain of *anxiousness and fainting spells* (China), and there is with them an inward pressure at the left edge of the sternum, with night sweats, palpitations, stitches and congestion to the chest. The attack is worse at night, from wine (Acon.), accompanied by a *hollow, racking, spasmodic cough* (Ipec.), provoked by a tickling in the larynx and trachea, and **the blood is bright-red, foamy* and abundant (Acon., Millef., Ipec., etc.).

MILLEFOLIUM. ‡—Suitable in suppressed hæmorrhoids and menses, as well as in checked lochia, *phthisis*, or after a fall (Arn., Ruta.), especially if there is cough with **frequent spitting of florid blood* (Acon., Dulc., Led., Ipec., etc.); oppression of chest, palpitations, ebullitions, *fine piercing pain and bruised* feeling, worse under the left scapula (Ran. bulb.).

NUX VOMICA.—Is the remedy when there is congestion to the chest (Acon., Arn., Bell., Opium, Phos.), with heat and burning (Arn., Ars., Carbo veg.), and the trouble is *provoked* by *a fit of passion;* in individuals *addicted to strong drinking* (Hyos., Opi.), especially if there should be present a *titillating* (Arn., Bell.), *racking cough* (China, Ipec.); or the blood raised, even after a little hawking (Acon., Ipec., Sulph.). The attack is usually in the morning, and may be due *to suppressed hæmorrhoidal flow* (Carbo veg., Lycop., Phos., Sulph.) *or debauchery.*

OPIUM.—With *Nux vom.* and *Hyos.* forms a group for *hæmoptysis in drunkards.* According to Jahr *Hyos.* is the remedy when *Opi.* and *Nux vom.* have been given and failed to do any good, while *Nux vom.* is often suitable after *Opi.* The distinction of *Opium* consists principally in the character of the **blood which is frothy, viscid, thick* (Arn., Rhus), mixed with mucus (Arn., Bell.). It has,

‡Erechthites is a rival of Millef. in bright-red epistaxis and in hæmoptysis.—FARRINGTON.

besides rush of blood to the chest (Acon., Arn., Bell., Phos.), oppression and dyspnœa (Ferr., Ipec., Phos.), flushed face (Acon., Bell., Nux v.), burning about the heart, feeble voice (Ars., Bell., Ferr., Phos., Sulph.), tremor, heat in chest (Nux v.) and coldness of the legs (Ars., Carbo v., China). (Lilienthal gives *absence* of all pain.)

PHOSPHORUS.—Has hæmorrhages from all the outlets of the body, due to its disorganizing effect upon the blood-life. It answers to the *tubercular diathesis, especially in tall, slender or rapidly growing girls, inclined to stoop.* In *hæmoptysis, following suppressed menstruation,* it shares honors with *Pulsatilla.* Its selection does not depend on the quality or color of the blood, but on the manner in which the bleeding occurs. *If the flow is scanty,* constituting what is termed *blood-spitting,* it is usually attended by *a dry, tight, fatiguing cough,* which may have existed long before the initial discharge, and sometimes intermixed with mucus (Arn., Bell., Opi.). *If profuse, it pours out freely,* and *then ceases for a time.* Occasionally the scanty discharge alternates with a profuse flow, so obstinate, at times, as to cause great debility (Ars., China). In such cases it will often arrest and always palliate the work of destruction, which is going on in the lungs, as indicated by the critical discharges. Accompanying symptoms are *oppression, weight, fulness* and *tension in the chest, hoarseness* (China, Sulph.); *palpitations of the heart* (Acon., Arn., Ars., Bry., Sulph.) and *intra-scapular cramp.* Periodicity seems to be another leading feature of *Phos.*, the trouble often increasing at the same hour. The attack is principally worse in the morning (Ars., China, Nux v.) and after talking (Ferr.). (Lilienthal gives worse from evening till midnight.)

PULSATILLA.—Is to the suppressed catamenial flow what *Nux v.* is to the hæmorrhoidal. In these respects *Phos.* is a rival of *Puls., Sulph.* of *Nux v. Pulsatilla* is especially indicated in obstinate cases if **the blood is dark and coagulated* (Arn., Ham.); *coughed out in pieces; after the suppression of the menses* (Ipec., Phos., Verat. alb.). It is the remedy for *timid, weeping women, inclined to grief,* with pale face (Ars., China, Ferr.), anguish and shivering. The attack is at night (Ferr., Hyos., Rhus), and accompanied by pain in the lower part of the chest (Rhus).

RHUS TOX.—Is, next to *Arnica*, the remedy in *traumatism* (Ipec., Ruta.). *Arnica* is indicated when the injury is violent enough to produce the rupture of a vessel. *Rhus* when the exterior violence, causative of the trouble, consists principally of excessive strains, as those required to blow a wind instrument, or lift heavy weights. The attack is more violent at night (Ferr., Hyos., Puls.) and the least mental excitement renews it. It may be accompanied by a *dry, tearing cough* (China, Ipec., Nux v.); hoarseness (China, Phos., Sulph.); heat (Arn., Ars., Carbo v.), and weakness in the chest (Sulph.), hindering speech (Stann.). The patient must move, because quiet makes dyspnœa worse; in fact, rest aggravates all the symptoms. Pain in the lower part of the chest (Puls.) is another concomitant. **The blood is bright-red* (Acon., Arn., Ars., Bell., China, Fer., Ipecac, Millef.), or *slimy, viscid, thick* (Arn., Opi.).

SULPHUR.—Follows *Nux vom.* when the trouble sets in *upon the suppression* of *the hæmorrhoidal flow* and the latter has not been sufficient to correct the abnormal departure. It is also suitable after *Nux v.* or *Ars. to prevent relapses.* It is especially indicated in chronic cases, *when blood is raised even after a little hawking* (Acon., Ipec., Nux v.); there is a great deal of *hoarseness* (China, Phos.,); *stitches through chest*, extending into left scapula; *oppressed breathing, with anxiety* (Acon., Ars., Puls.); *soreness* and *pressure in chest*, as well as heat and weakness (the latter principally when lying down in the evening, or when talking); pain under the sternum (Led.); *palpitations of the heart* (Acon., Arn., Ars., Phos.); and *sweetish taste in the mouth* (Acon., Ars., *in throat;* Bry.; Ipec., Phos., *sputa*; Plumb., Puls., *saliva*). *Sulphur* has also *salty sputa* (Phos., *salty taste;* Ars., Bell., China, Hyosc., *saliva;* Nux v.), which is, like the *sweetish taste*, a premonitory symptom. Sometimes *the blood is mixed with pus* (Phos.;—mixed with mucus, Arn., Bell., Opi., Phos.), *or a dry, tickling cough*, brings up a dark, bloody sputum.

SPECIAL REMEDIES.

ARSENICUM.—Hæmoptysis consequent upon losses of blood, with *great deal* of *weakness* (China), *burning heat all over*, dry cough, oppressed breathing, palpitation, intra-scapular pain (China,

Ferr., Phos.), and salty taste (Bell., Calc., Carbo v., China, Hyos., Nux, Phos.). In drunkards (Hyos., Nux, Opi.). From suppressed menses (Phos., Puls., Senec.).

ANT. CRUD.—Hæmoptysis in the aged (Coni., Opi.), *with heat* and *pain in the chest* (Ars., Bry., Carbo v.), especially if there should be present *exhaustive night-sweats* and the patient could not stand the heat of the sun. The attack is worse in summer time and may come after bathing. *A gradually declining cough, ending finally in a mere hacking is very characteristic.*

ANT. TART.—Indicated when after hæmoptysis there still remains for a long time *a bloody, slimy expectoration.* This drug has also *salty taste, oppressed breathing, fulness and constriction of chest; rising of warmth from the heart; and palpitations.*

BRYONIA.—I have given this remedy three times to a Spanish lady, who had two previous attacks in Barcelona, one every year, making five in all. She told me they always appeared in place of the menses, early in the morning, as soon as she commenced to move about and that there was a history of consumption in the family. I was led to its use, principally, *by the state of vascular erethism*, a *chronic, dry, hacking cough* and *a sharp, stitching pain in the left infra-mammary region*, going *through shoulder, worse on motion, coughing, or during inspiration* of which she complained when I first saw her. She had besides a persisting *sweet taste* and *the blood, which was of a bright red color, required little effort to be raised.* I could not see a reason why *Bryonia* would not act here as in *vicarious nose bleed* and my conclusion was crowned with the best result, as this lady has had no other attack since 1883. We must also remember that *pleurisy* is the antecedent of many cases of phthisis and hæmoptysis a symptom which may occur at any period of the trouble.

CARBO VEG.—Has *burning* in *chest; excited action of the heart; difficult breathing* (Acon., Ars., Ipec., Phos., Sulph.); and *salty taste* (Ars., Bell., China, Nux v.), all premonitory symptoms of hæmoptysis. Its leading feature, however, is the *excessive dyspnœa, with anxiety* (Acon., Ars., Puls., Sulph.), *but no restlessness.* The patient desires to be fanned; must have more air; is hoarse (Phos.); his face is pale, especially before and after every attack; the skin is cold, and he is tormented by violent spells of cough.

CALC. OST.—*Blood spitting when coughing* and *even hawking, with roughness* and *soreness in chest, sweetish taste* (Ipec., Phos., Puls., Stann.), palpitation, anxiety, marked pulsation in the blood vessels (Acon.), and tremulous pulse; especially if there should be stitches in chest, worse from motion (Bry.), cutting through back, or crawling inter-scapular pain.

COLLINSONIA.—*When the spitting of a thick, dark, coagulated blood* (Arn., Ham., Puls.), *follows the suppression of a similar anal flow*, especially in persons suffering from blind or bleeding piles, with weight in the rectum and obstinate constipation (Nux v., Sulph.). Also when due to cardiac trouble (Cactus).

CONIUM MAC.—*In the aged* (Opi.) *and in those who have the pernicious habit of masturbation*, with trembling of the limbs and sudden loss of strength while walking; especially if they should complain of a dry spot in the larynx, with almost constant irritation to cough and marked hoarseness; or of a very fatiguing, spasmodic, dry cough, worse in the evening, and when lying down, with sharp thrusts through the chest and evening fever; or of a loose, ineffectual cough, with difficult, bloody, purulent expectoration; short wheezing breathing, and frequent attacks of suffocation.

ELAPS COR.—*Expectoration of dark blood* (Sulph. ac.), with a feeling of a tearing in the region of the heart, especially *if the right lung is affected* (Lach., *left*). Before cough a drop of blood in mouth.

ERGOTIN.—When, after bleeding, the patient complains of *acute, sharp*, burning pains in chest (Ars.) above the sternum. Palpitation. Ardent fever.

IODIUM.—This drug is very much neglected in hæmoptysis. According to Dr. Farrington it is a capital remedy when there is *tendency to bronchial* and *pulmonary congestion* and *hæmorrhage*. In *Iodium* we find, besides the predominant vascular symptoms, impeded breathing, tightness across the chest, dry cough, with stitches and burning in chest, as well as an abundant expectoration of blood-streaked mucus, attended by weakness of the chest. *The salty or sweetish taste is also very marked in this medicine.*

KREOSOTE.—No less neglected is also *Kreosote*, a drug which does not only answer well the *tubercular diathesis*, but presents such

important symptoms as frequent blood-spitting or expectoration of black, coagulated blood; severe, bruised, pressive chest pains; afternoon fever, morning sweat, shortness of breath, oppression and anxious feeling of heaviness in the chest.

LACHESIS.—*When the hæmorrhage leaves a charred straw sediment*, especially in tuberculous patients; after pneumonia, with soreness, burning and weight in chest; stitches in the left chest; *left lung mostly affected* (*Elaps*, right lung); during climaxis (Sang.).

MYRTUS COM.—*Hæmoptysis in tuberculous patients*, who complain of stitching pains in upper part of left chest, extending to left shoulder-blade; worse on coughing.

SANG. CAN.—*Hæmoptysis during phthisis pulmonalis*, with burning and stitches in chest, especially from right side to shoulder; rust-colored sputa (Phos.); night sweats and extreme dyspnœa. In women suffering from amenorrhœa or during or after climaxis.

SENECIO.—*In the bleeding of incipient phthisis, with troublesome cough*, first dry and then loose; copious expectoration of yellow mucus, streaked with blood, and a sensation of rawness and soreness in the chest. *Also when due to suppression of the menses* (Millef., Puls.), *or after venesection*, with great deal of weakness (Ars., China).

SEPIA.—*Hæmoptysis in millers, due to the continuous inhalations of flour dust*, especially if the bloody expectoration takes place when lying down, or when coughing; dry, spasmodic cough, excited by tickling in the chest; congestion, weight (more if left side), empty feeling (Stann.), stitches, soreness (in mid-chest), oppression, shortness of breath, excited action of the heart, and a salty taste are additional indications.

STICTA PULM.—*Chronic bleeding of a dark color in consumptives*, with tickling in the larynx and bronchi; incessant, wearing or racking cough, and pain in the left side below the scapula; or the cough may be loose in the morning, with easy expectoration of bloody mucus, less free during the day, or accompanied by oppression, worse from midnight till morning, and coexisting with splitting, frontal headache and epistaxis.

STANNUM.—*Hæmoptysis, with tendency to copious expectoration*,

and sore or empty feeling in chest. Chest so weak he cannot talk (Rhus.); stitches in chest, knife-like, below the axilla; *hoarseness* (Carbo v., Phos.), *sweet taste* (Ars., Bry., Ipec.), paroxysmal cough, oppressed breathing, profuse, debilitating sweats, and small, frequent pulse, are all symptoms found under *Stannum.*

SULPHURIC ACID.—Like *Phosph.*, has hæmorrhages from all the outlets of the body, but *the blood is dark* (Crotal.) *and profuse from the lungs*, without vascular erethism. *It is especially indicated in consumptives and in broken-down constitutions, subject to mucous discharges. Also in persons who suffer with piles and are enfeebled by repeated losses of blood* (China). Gastric complications; dry cough, with soreness between scapulæ, with morning expectoration of dark blood (Elaps), or of a thin, yellow, blood-streaked mucus, tasting sour; and sensation of great weakness in chest are all indicative of *Sulph. acid.* Likewise the remedy for spitting of blood in climaxis (Lach., Sang.), and after typhus, with cough (Tart. em.).

REPERTORY.

PREMONITORY SYMPTOMS.

Constriction in chest:—Acon., Arnica (R.), Ars., Bell., Bry., Cact., Carbo v., Ferr., Ham., Hyos., Ipec., Kreos., Lach., Nux v., Opi., Platin., Phos., Puls., Sang., Stann., Stram., Tart. emet.

Excited heart:—Acon., Ars., Bell., Bry., Calc., Cactus., Carbo v., China, Cocc., Ferr., Ipec., Lach., Nux v., Opi., Phos., Puls., Rhus, Senec., Sep., Spig., Sulph., Sulph. ac.

Heat in chest:—Acon., Ars., Bry., Bell., Carbo v., Hyos., Nux v., Opi., Phos., Plat., Puls., Rhus, Sang., Sulph., Sulph. ac.

Laborious breathing:—Acon., Arn., Ars., Bell., Bry., Calc., Carbo v., China, Dulc., Ferr., Hyos., Ipec., Kreos., Lach., Led., Nux v., Opi., Phos., Plat., Puls., Rhus, Sang., Sep., Stann., Sulph., Tart. emet.

Oppression :—Acon., Ant. c., Arn., Ars., Bell., Bry., Cactus, China, Coni., Crot., Dulc., Ferr., Hyos., Ipec., Kreos., Lach., Mill., Nux v., Opi., Phos., Puls., Rhus, Senec., Sep., Stann., Sticta, Sulph., Tart. emet.

Salty taste :—Ars., Bell., Calc., Carbo v., China, Hyos., Nux v., Phos., Sep., Stann., Sulph., Tart. emet.

Sweetish taste :—Acon., Ars., Bry., Calc., Ipec., Phos., Plumb., Puls., Stann., Sulph.

Tickling in air passages :—Acon., Arn., Calc., Carbo v., Coni., Dul., Ferr., Ipec., Lach., Nux v., Phos., Rhus, Senec., Sep., Sticta, Sulph.

Tickling under sternum :—Acon., Ipec.

Violent cough :—Ars., Bell., Cactus, Calc., Carbo v., China, Coni., Dulc., Hyos., Ipec., Lach., Led., Nux v., Opi., Phos., Puls., Rhus, Sep., Stann., Sulph.

CONCOMITANTS AND SUCCEEDING SYMPTOMS.

Blood ; bright red (pure) :—Acal (A. M.)., Acon., Arn., Bell., Bry., China, Dulc., Erech., Ferr., Hyos., Ipec., Led., Mill., Rhus.

" *and frothy :*—Acon., Arn., Ipec., Led., Mill.

clotted :—Acal (P. M.)., Arn., Coll., Croc., Ham., Hyos., (partially), Puls., Rhus.

" *and dark :*—Arn., Coll., Ham., Puls.

" *pale and brown :*—Rhus.

dark :—Acal (P. M.)., Arn., Coll., Elaps, Ham., Kreos., Phos. ac., Plat., Puls., Sticta, Sulph. ac.

easily coagulating :—Ferr.

ejected in pieces by cough :—Puls.

frothy :—Acon., Arn,, Ipec., Led., Mill., Opi.

hot :—Acon., Bell.

imparting a sense of heat :—Bell.

in a grumous mass :—Platina.

leaving a charred straw sediment :—Lach.

light :—Ferr., (Merc.).

like a simple warm current :—Ham.

lumpy :—Crocus, Ferr.

Blood mixed with mucus:—Arn., Bell., Ipec., Opi., Phos., Senec., Sticta, Sulph., Sulph. ac.

pale, clotted and brown:—Rhus.

pours out freely and then ceases for a time:—Phos.

raised with little effort:—Arn., China, Ferr., Ham., Ipec., Phos.

slimy, viscid and thick:—Arn., Croc., Merc., Opi., Rhus, Sec.

thick, black and tarry:—Platina.

Bleeding brought on by a cold:—Dulc.

" *least cough:*—Acon., Bry., Mill.

" *racking cough:*—China, Ipec., Led., Nux v.

" *violent " :*—Acal., Arn., Bell., Bry., China, Ipec.

" *loose, protracted cough:*—Dulc.

" *fit of passion:*—Nux v.

" *an injury:*—Arn., Ipec., Ruta.

" *little hawking:*—Acon., Bry., Ham., Ipec., Nux v., Sulph.

" *strain,* (as blowing, lifting, etc.,) *:*—Arn., Rhus.

coming, as if vomited up:—Arn., China, Ferr., Ipec., Phos.

dangerous:—Acon., China, Ferr., Ham., Ipec., Opi., Phos.

habitual:—China, Rhus.

leaving a bloody taste:—Bell., China, Ipec.

periodical:—Carbo v., Kreos., Phos.

profuse:—Acon., Arn., Ars., Bell., Carbo v., China, Croc., Dulc., Ferr., Hyos., Ipec., Led., Mill., Nux v., Opi., Phos., Puls., Rhus, Sulph. ac.

scanty:—Arn., Bell., Bry., Carbo v., China, Coni., Dulc., Ferr., Ipec., Phos., Rhus, Sticta, Sulph.

without cough:—Arn., China, Ferr., Ham., Ipec., Phos.

when due to heart trouble:—Acon., Cact., Coll.

" *suppressed hæmorrhoidal flow:*—Acon., Carbo v., Coll., Nux v., Sulph., Sulph. ac.

" *it occurs at the menstrual period:*—Bry., Ipec., Phos., Puls., Verat. alb.

Bleeding when the least mental excitement renews it :—Rhus.
" *mental symptoms disappear with the attack :*—Plat.
" *weakness of chest hinders speech :*—Dig., Rhus, Stann.
" *there is a bloody, slimy expectoration left after :*—Ant. tart.
in the aged :—Ant. c., Coni., Opi., Carbo v.
" *broken down constitutions subject to mucous discharges:*—Sulph. ac.
" *chronic cases :*—Sticta, Sulph.
" *climaxis :*—Lach., Sang., Sulph. ac.
" *consumptives :*—Bry., Dulc., Iod., Kreos., Lach., Mill., Myrt., Phos., Sang., Stann., Sticta, Sulph. ac.
" *debauchers, who are irritable and thin :*—Nux.
" *girls, rapidly growing :*—Phos., Phos. ac.
" *obstinate cases :*—Acal., China, Ipec.
" *onanists :*—Ferr.
" *overgrown boys, with weak chest :*—Iod.
" *persons addicted to spirituous liquors :*—Ars., Hyos., Nux v. Opi.
" " *tall, slender, inclined to stoop :*—Phos.
" " *thin, stoop-shouldered :*—Sulph.
" " *feeble, cachetic :*—Sec., Sulph. ac.
" " *young and robust :*—Acon., Bell.
" *plethoric individuals :*—Acon., Arn., Bell., Calc. c., Ferr., Ign., Nux v., Phos., Sec.
" *pregnancy :*—Acon., Sep.
" *rheumatic or gouty patients :*—Bry., Rhus, (Led., after abuse of Colchicum.).
" *traumatism :*—Arn., Colch., Ipec., Rhus, Ruta.
" *vicarious menstruation :*—Bry., Ham., Lach., Phos., Puls.
" *women, debilitated from exhausting discharges :*—China.
" *women, delicate, chlorotic :*—Ferr.
" *women, hysterical, mild, but easily excited :*—Ign.
" *women, pale, delicate, always cold :*—Led., Puls., Sep.
" *women, tall, slender, disposed to stoop :*—Phos.
" *women, thin, irritable, with dark hair :*—Nux.
" *women, thin, feeble and cachectic :*—Secale.

Bleeding in women, timid, weeping, inclined to grief :—Puls.
" *women, weeping, but haughty and fault-finding :*—Plat.
" *old women, after the menopause :*—China.
preceded by burning in chest :—Acal., Arn., Ars. Bell. (R)., Bry., Carbo v., Phos., Plat., Puls., Sep., Sulph. (rising to face).
" *by burning in the sternum :*—Sang., Kreos., (from sternum to throat).
" *by burning in the sternum :*—Acon., Ars., Carbo v., Phos., Puls.
" *by congestive symptoms :*—Acon., Bell., Bry., China, Carbo v., Ferr., Nux v., Phos., Puls., Rhus, Sep., Sulph.
" *by a dry cough :*—Acon., Arn., Ars., Bell., Bry., China, Ferr., Hyos., Ipec., Nux v., Phos., Puls., Rhus, Sulph.
" *by fulness in chest :*—Acon., Calc., Carbo v., Ferr., Phos., Puls., Sep., Sulph., Sulph. ac.
" *by palpitation*, (from plethora) :—Aco., Bell., Ferr., Lach., Nux v., Opi., Phos., Sulph.
" *by a sense of boiling in the chest :*—Acon.
" " " *bubbling in chest :*—Ipec.
" " " *dryness in chest :*—Ferr.
" " " *gurgling at heart :*—Bell.
" *by shooting in sternum :*—Bry., Sulph.
followed by acute sharp burning pain in chest :—Ergotin.
" *by burning under sternum :*—Acon.
" *by ebullition :*—Mill.
" *by weakness :*—Ars., China.
" *by a reappearance of mental symptoms :*—Plantina.
after the abuse of Colchicum :—Led.
" *bathing :*—Ant. c.
" *debauchery :*—Ars., Nux v., Opi.
" *exposure to cold and rain :*—Ipec., Rhus.

Bleeding after effects of (*Sequelæ*) *:*—Ars., Carbo v., China, Coffea., Ign., Sulph.
" *exhausting discharges :*—China.
" *a fall or blow :*—Arn., Mill., Ruta.
" *masturbation :*—Coni.
" *mechanical injuries :*—Arn.
" *strain and fatigue :*—Arn., Rhus.
" *suppressed hemorrhoids :*—Carbo v., Coll., Lyc., Mill., Nux v., Phos., Sulph.
" " *lochia :*—Mill.
" " *menses :*—Ars., Ipec., Mill., Phos., Puls., Senec., Verat. alb.
" *talking :*—Ferr., Phos.
" *typhus, with cough :*—Sulph. ac., Tart. eme.
" *venesection :*—Ars., China, Ferr., Ipec., Senec.
Bleeding with absence of all pain :—Opi.
" *anguish and shivering :*—Puls.
" *anxiety :*—Acon., Ars., Calc., Led., Puls., Sulph.
" *arterial excitement :*—Acon., Cactus.
" *bloody expectoration*, (after) *:*—Ant. tar., Bell., Elaps, Sticta, Sulph., Sulph. ac.
" *breathing* (laborious)*:*—Acon., Arn., Bell., Bry., Carbo v., Ferr., Ipec., Phos., Puls., Spong., Sulph.
" *bruised feeling:*—Arn., Mill., (worse under L. scapula)., Nux v., (in whole system, when touched).
" *burning and heat in chest :*—Arn., Ars., Bell., Carbo v., Nux v.
" *burning about the heart :*—Opi.
" *burning heat all over :*—Ars.
" *chills :*—Acon., Ars., Ipec., Puls.
" *collapse, cold breath and weak pulse :*—Carbo v.
" *cold legs and heat in chest :*—Opi., (Ars.).
" *coldness of the skin and limbs :*—Ars., Carbo v., China.
" *congestion to chest :*—Acon., Arn., Bell., Cactus., Led, Nux v., Opi., Phos.

Bleeding with constipation (obstinate):—Bry., Coll., Nux v., Opi., Phos., Verat. alb.
" *constriction in chest*:—Arn., Bell., Ipec., Phos.
" " *of heart*:—Arn., Cact., Iod., Kali c.
" *cough*:—Acal., Arn., Bell., Cact., China, Coni., Croc., Dros., Dulc., Ferr., Ham., Led., Mill., Nux v., Sec.
" " (*constant, titillating and a dry spot in the larynx*):—Coni.
" " (*convulsive*):—Cact., Dros., Led.
" " (*chronic, dry and hacking*):—Bry.
" " (*dry*):—Arn., Ars., Bell., Bry., China, Ferr., Hyos., Phos., Sulph.
" " (*dry, tight and fatiguing*):—Phos.
" " (*dry and tearing*):—China, Ipec., Nux v., Rhus.
" " (*hallow, racking, spasmodic*:)—Ipec., Led.
" " (*racking*):—China, Ipec., Nux v.
" " (*slight*):—Ferr.
" " (*tickling*):—Arn. (under sternum), Bell., Dulc., Ham., Nux v.
" " (*titillating*):—Arn., Bell., Nux v.
" " (*titillating and racking*):—Nux v.
" " (*violent*):—Acal., Carbo v., China, Dros.
" " (*in violent spells*):—Carbo v.
" *debility*:—Ars., China, Ferr., Ipec., Phos., Verat. alb.
" *desire to cough*:—Dulc.
" " *to lie down*:—China, Ferr.
" *dimness of vision*:—China.
" *dyspnœa*:—Carbo v. (excessive), Ferr., Ipec., Opi., Phos., Sang., Sulph.
" *emaciation*:—Acal., Ars., Calc., China, Phos., Phos. ac., Sil., Sulph., Sulph. ac.
" *empty feeling in chest*:—Stann., Sep.
" *epistaxis and frontal headache*:—Sticta.
" *erethism (vascular)*:—Acon., Bry., (without it Sulph. ac.).
" *face, (flushed)*:—Acon., Bell., Ferr., Nux v., Opi.
" " (*livid*):—Ipec., Opi., Verat. alb.

Bleeding with face (*pale*) :—Ars., Carbo v., (before and after attack), China, Ferr., Puls., Sep., Sil.
" *fainting spells* :—Calc., China, Croc., Led.
" *faintiness* :—Acon. (on rising), Calc., Croc., Lach.
" *fatigue*, (*great, after talking*) :—Ferr., Hyos., Ipec., Phos.
" *fear of death* :—Acon., Ars.
" *fever* :—Acal. (slow, small, depressed pulse)., Coni. (P. M.), Ergotin (ardent), (Acon).
" *fulness of chest* :—Acon., Arn., Bell., Calc., Lach., Opi., Phos., Rhus., Sulph.
" " *of head* :—Acon., Bell., China, Ham.
" *headache* :—Bell. (throbbing), Ham. (dull frontal).
" *heat and burning in chest* :—Arn., Ars., Bell., Carbo v., Nux v.
" *heat* (*burning all over*) :—Ars.
" *heat in chest and cold legs* :—Opi., (Ars.).
" " *and pain in chest* :—Ant. c.
" " *under the sternum* :—Acon., Nux v.
" " *and weakness in chest* :—Rhus, Sulph., Sulph. ac.
" *hoarseness* :—Carbo v., China, Coni., Phos., Rhus, Sulph.
" *inability to lie down* :—Ham. (from congestion).
" *menses* (*disturbed*) :—Ars., Bry., Ipec., Mill., Phos., Puls., Senec., Verat. alb.
" *mind full of apprehensions* :—Acon., Ars.
" *mind* (*calm*) :—Ham.
" *nausea* :—Ipec., Nux v., Verat. alb.
" *night sweats* :—Ant. c., Calc., Carbo a., Carbo v., China, Ipec., Lach., Led., Nux v., Phos., Phos. ac., Puls., Rhus, Sep., Silc., Sulph.
" *oppression* :—Ferr., Ipec., Mill., Opi., Phos., Sulph.
" *pain* (*burning*) :—Acon., Arn., Ars., Bell., Ergotin., Lach.
" " (*in lower chest*) :—Puls., Rhus, Sec.
" " (*when coughing*) :—Arn. (contusive), Bry., Sec.
" " (*fine, piercing in chest*) :—Mill.

Bleeding with pain (interscapular):—Ars., Calc. (crawling), China, Ferr., Phos.,
" " *in the sternum*:—China, Led., Sulph.
" " *under the sternum*:—Led., Sulph.
" " (*stitching, in L. infra-mammary region*:—Bry.
" *palpitation*:—Acon., Arn., Ars., Calc., China, Ferr., Led., Mill., Phos., Sulph.
" *periodical aggravation*:—Phos.
" *piles*:—Coll., Nux v., Sulph., Sulph. ac.
" *pressure under sternum*:—Acon., Kreos. (inward)., Led (inward, at left edge)., Phos. ac. (impeding respiration), Sep. (on upper part as from a weight).
" *pulsation of blood-vessels*:—Calc.
" *pulsating carotids*:—Acon., Bell., China.
" *pulsation under sternum*:—China, Sel., Sulph.
" *pulse, (hard, full, bounding)*:—Acon., Bell.
" " (*small and frequent*):—Ipec.
" " (*tremulous*):—Calc.
" " (*weak, slow and intermittent*):—Carbo v.
" " (*weak, rapid, intermittent*):—China.
" *relief of chest symptoms*:—Brom.
" *restlessness (nervous)*:—Acon., Ars.
" *rheumatism (alternating)*:—Led.
" *ringing in the ears*:—Bell., China.
" *roughness and soreness of chest*:—Arn., Calc., Phos.
" *a sense as if chest were filled with blood*:—Bell.
" " *of emptiness in chest*:—Stann.
" " *of excoriation above sternum*:—Phos.
" " *of heat in the bleeding part*:—Sulph.
" " *of internal ulceration in mid chest*:—Puls.
" " *of weight in the bleeding part*:—Sep.
" *shivering and anguish*:—Puls.
" *sleep (unrefreshing)*:—Ferr., (Coni.).
" *soreness and empty feeling in chest*:—Stann.
" " *and pressure in chest*:—Sulph.
" " *between the scapulæ*:—Sulph. ac.

Bleeding with soreness under sternum :—Led.
" *sparks before the eyes :*—Bell.
" *spasms :*—Hyos., Mosch.
" *sputa :*—Phos., Sang (rust colored)., Ant. tar (bloody, slimy)., Coni (copious, purulent).
" *stitches in chest :*—Bell. (apex of r. lung), Bry. (through chest to back), Calc. (cutting through back). Dulc. (here and there), Led., Myrt. (upper l. chest to back), Sulph. (through chest into l. scapula).
" *stitches* (*dull, through sternum*) *:*—Arn.
" *stitches* (*under the sternum*) *:*—China.
" *sweats*, (*debilitating*) *:*—Ars., Carbo a., China, Ferr., Phos., Phos. ac., Sep., Silica., Sulph., Verat. alb.
" *sweats*, (*cold*) *:*—Ars., Carbo v., China, Croc., Hyos., Ipec., Sec., Verat. alb.
" *sweats*, (*hot*) *:*—Bell., Bry., Cham., Lach., Opi., Phos.
" *taste of blood*, (*protracted*) *:*—Bell., Calc., China, Ham., Ipec.
" *taste of sulphur :*—Ham.
" *tension and weight in chest :*—Phos.
" *tickling*, (*constant and desire to cough*) *:*—Dulc.
" *tickling in the larynx :*—Led., Sticta.
" *tickling in supra-sternal fossæ :*—Phos. ac., Silica.
" *tickling under sternum causing gagging :*—Lach.
" *tightness in chest :*—Ham., Ipec., Phos.
" *tremors :*—Coni., Lach., Opi.
" *tremulous heart :*—Crotal., Opi.
" *voice* (*feeble*) *:*—Ars., Bell., Ferr., Opi., Phos., Sulph.
" *weak chest :*—Rhus, Stann., Sulph., Sulph. ac.
" *weight and tension in chest :*—Phos.
Bleeding worse at night :—Ferr., Hyos., Led., Puls., Rhus, Sec.
" *in the morning :*—Acal., Ars., Bell., China, Nux v., Phos., Sulph.
" *from evening till midnight :*—Phos.
" *from midnight till morning :*—Sticta.
" *in the evening :*—Coni.

" *in summer time:*—Ant. c.
" *during rest:*—Dulc., Rhus.
" *from least exertion:*—Bell., China, Ferr., Ipec.
" *from wine:*—Acon., Led.
" *after exercise:*—Bell., Bry., China, Ferr.
" *after bathing:*—Ant. c.
" *after talking:*—Ferr., Phos.

For the debility after the arrest of the bleeding:—Ars., China, Ferr., Ign.

To prevent relapses:—Ars., Nux v., Sulph.

EDWARD FORNIAS, M. D.

HÆMORRHAGES FROM THE ALIMENTARY TRACT.

Hæmorrhages from the alimentary tract show either at the mouth or anus, or the bleeding takes place into the serous cavities, or extravasates into the tissues, or, when death takes place too suddenly to allow time for its expulsion, it may remain hidden in the tube itself. When the blood does not show itself, however, we can only conjecture as to the likelihood of a hæmorrhage. Hence we have to do here mainly with bleedings from the mouth or anus.

How shall we, at the bedside, determine the diagnosis of the site of the trouble and its cause. If the discharge is not too profuse so as to flood the mouth, an examination of the same and of the fauces will determine whether it comes from the tongue, the gums or from the posterior nares. The history of the case and the knowledge of the extraction of a tooth, or some injury to the mouth, or the presence of epistaxis will also help in such a case. These cases of hæmorrhage from the buccal cavity are not often serious, and yet they should not be overlooked, as I shall presently show.

None of these signs being present, the bleeding probably comes from an aneurism, from the larynx or bronchi, from the lungs, or from the stomach. In the first case, the blood comes in a flood, is bright, and there is the history of signs of an aneurism.

A *flood* of blood may come also when an artery of some size is eaten into by ulceration in the lungs or in the stomach. Blood from the larynx or bronchi, though coughed up, is usually less in

quantity, less bright in color, and less often met with than blood from the lungs. It is, however, often impossible to determine certainly whether the blood is from the lungs or tubes leading to them. Either may be mixed with sputum. Hæmorrhages from the œsophagus may be considered with those from the stomach, though not often met with, except from injury or in cancer. Hæmatemesis may be distinguished from hæmoptysis by the dark color of the blood, its admixture with food, and its being gulped or vomited up, rather than coughed up. It is usually preceded by signs of gastric disorder, by a sense of weight at the epigastrium, and subsequently there is altered blood found in the stools.

Bleeding from the stomach may occur in gastric ulcer, in cancer, in some forms of gastritis, especially in that form caused by swallowing corrosive poisons. It may be vicarious in place of the menses, or it may occur from the congestion of the portal circulation in diseases of the heart, liver or spleen. In these latter cases a congestion or inflammation of the gastric mucous membrane will have previously developed, and the signs of the primary affection will be present. In gastritis, if any at all, the bleeding is slight and in spots or streaks, mixed with the vomited matter.

In gastric ulcer, the bleeding may be profuse, and the other signs of that lesion may be found, as soreness at the epigastrium, usually worse in a circumscribed spot, pain increased by food, especially solid food. There is also often present a gnawing pain in lower dorsal vertebræ.

In cancer we have the vomiting of dark or coffee-ground-like substances. In ordinary ulcer, this is also present when the bleeding has been slow and has had time to mix with the food. It is not pathognomonic of cancer. There is also deep-seated pain, generally burning or lancinating in character, more continued and less influenced by taking food than in ulcer. The pain may be slight or excessive, and it may not be lancinating at all. If the cancer ulcerates, of course the pain takes on more the character of the simple gastric ulcer. Above all, in cancer there can generally be found the evidences of a tumor. In either cancer or ulcer, if an artery is eaten through, the hæmorrhage will be excessive, will be more florid in color, and some of the blood entering the larynx may excite a cough, and thus hæmoptysis be simulated, but later

there would be dark blood in the stools and other distinctive signs.

Vicarious hæmatemesis may be confounded with that from ulceration, in that they are both often found in anæmic women, and in such cases, the hysterical tendency also develops an abnormal tenderness of the abdomen, or pains in the stomach. I recall a case in which, while there was no hæmatemesis, most severe attacks of gastralgia with tenderness of the epigastrium, and dyspeptic symptoms were present. After she had suffered for years from it, under several physicians, an examination revealed tenderness of the ovaries and a displaced womb, and treatment directed to these conditions cured the gastralgia.

Bleeding from points in the intestinal tract below the stomach generally passes downward and shows itself at the anus, unless it should break through the peritoneal coat and pass into the abdominal cavity. In the latter case, being internal, it would only be known by the shock attendant upon perforation, by the exhaustion and the subsequent pain and peritoneal inflammation.

As to the part of the bowel from which the flow of blood comes, great uncertainty must exist, but the pain may point out approximately, and, in some diseases, as typhoid fever or dysentery, the pathology may assist still more in determining the location of the lesion.

Dark blood, or that mixed intimately with the fæcal matter, most likely is from high up in the tract, possibly even from the stomach. Mixed with mucus, and bright-red in color and without the presence of fæces or only hard lumps, it points to the colon or rectum. The presence of hæmorrhoids or symptoms of dysentery will assist in deciding. It must be remembered, however, that a profuse flow of bright-red blood may come from an open artery high up in the tract, or from an aneurism, there being enough blood to keep bright in spite of the presence of the contents of the bowel.

Chronic ulcer or cancer of the colon or rectum, or fissure of the anus, may also be accompanied by hæmorrhage, but special symptoms will point to the presence of either. Inspection and palpation will determine.

As to the causes of hæmorrhages, besides the solution of con-

tinuity of the tissues, either from a wound or from ulceration, we may have a vitiated state of the blood, as in scurvy, purpura, typhus, or yellow fever, or a passive congestion of an already inflamed mucous membrane, as in catarrhal gastritis, from some obstruction to the return flow of blood in the liver, spleen, or heart. Still more, there is that peculiar state in some families, and possibly in some isolated individuals, called hæmophilia or the hæmorrhagic diathesis. Generally this is a hereditary condition transmitted from the father through the daughters (they themselves not showing) to their sons, yet I am inclined to think there are cases arising *de novo*, and that some cases of excessive bleeding from slight causes can be explained by such predisposition.

I recall here several cases: one of epistaxis in a man about fifty years old. He suffered for years from frequent excessive attacks when he would bleed for hours at a time. These attacks when frequent, often made him quite anæmic and weak. They start from blowing the nose, or sometimes without any irritation. He had suffered from nose bleed from a child, but real hæmorrhages have been present in paroxysms since he had relapsing fever twenty years ago. At that time, he had a blister on the lip which burst and bled very much, at times, for a week. Pressure of the lip between the thumb and fingers would stop it. Slight cuts gave very little trouble, but from a wounded finger the bleeding was so great as to require tying the artery above the injury.

The most of the family lived to be old, and there was no history of bleeding. The condition seemed to have been acquired since the fever. Crocus^{2x} relieved the attacks. He has not had any trouble for about a year.

Allen H., a boy of nineteen, was suffering from severe bleeding from the gums. While eating, he broke an old tooth which cut his gum slightly. The bleeding continued obstinately in spite of remedies, though styptic solutions were applied and then compresses saturated with persulphate of iron. The bleeding would stop and then break out again, the clots being like bladders full of liquid blood. These would burst and run freely. The gum of that side seemed to ooze all along. It had been bleeding for some days when I was called. The remedies indicated were given internally, but the flow of blood was very free. Finally com-

presses of Rohland's styptic cotton were applied and pressed in closely so as to form a compact mass about the gums. This was left in for two or three days, fearing to remove it, though the smell from the mouth was exceedingly putrid. Then by renewing it, keeping up the strength with liquid foods, and using Ferrum and other indicated remedies internally, the case was controlled in about two weeks. Much of the time the hæmorrhage was alarming, and, when finally controlled, the patient was extremely weak and quite bloodless. He had suffered five or six times from such attacks, the earliest being when about eleven years old. Some of these attacks were much longer. In a very severe one, he had been attended by Dr. M. Macfarlan who had pursued the treatment by internal remedies and compresses.

The boy had suffered from nose bleed from early childhood. Cuts would heal easily. He did not bleed from them to excess. Neither did he have hæmorrhages when he had typhoid fever some years before.

An older brother bled easily even from a cut, and finally died of consumption. The other brother and the sisters did not bleed. The maternal grandfather died from hæmorrhage from the lungs. No record of any other bleeder in the family. Since that attack, some six or eight years, there has been no attack of bleeding from the mouth, but some nose bleed, and only a few weeks ago an attack of bleeding from the anus, the source of which was not ascertained. The joints of this patient were rather large but not painful. He now seems in good health. I have no hesitation in calling this man a bleeder, a sufferer from hæmophilia, even though the family history is not as clear as somé, and the rheumatic joints are not marked.

Another case of excessive bleeding from the mouth seems to have been acquired only for the time, probably a case of pernicious anæmia. June 14th, 1874, Miss C. W. Four weeks ago had intermittent fever, for which she took Fowler's solution. Then she took quinine in large and repeated doses, even during the paroxysm. Finally missed the chills, but continued with Hubbell's bitter wine of iron. In two weeks, on the 12th, she had considerable fever and took quinine again. Eight grains made the head buzz and swim, but still had chill on the 14th. "Tired of quinine."

The present symptoms are as follows: Chill comes on at 10½ or 11 A. M. First pain in stomach, then chilliness half hour with headache, then shaking one hour with nausea: then fever two hours with worse headache and nausea, later profuse sweat. Backache and thirst through all the stages. Nat. mur.[3x] was given every hour in water.

On the 15th, after going down to teach her classes, and then taking her dinner, cleaned her teeth with a soft handkerchief. The gums began to ooze blood, and that to such a degree, that she used first salt and then alum to stop it, still the bleeding kept up. At 5½ P. M., there was a continual oozing from the gums, especially the outer aspect of the right lower jaw. It was sufficient to saturate a handkerchief with blood in a few minutes. Ipecac ought to have been given from the history, but Acon.[30] was used. There being no effect by 7 P. M., two drops of a saturated solution of per-sulphate of iron was added to a half glass of water. Rinse every few minutes and swallow some. At 10 P.M., she was better, bleeding was less; continued iron and added Acon.[0] in water, a dose every hour. I was called up at 3 A. M., and found the bleeding had returned severely. It had wakened her from sleep. I gave Ipecac every fifteen minutes for an hour or so without effect, then Carbo v.[30], then Phos.[6]. No effect. At 11 A. M., met Dr. M. Macfarlan, and at his suggestion used a strong solution of persulphate of iron as an application or wash, and gave Ferrum high, every half hour. No marked effect, even after the next night, for, at 7 A. M. the 16th, we have had "bleeding all night." The patient is weak and desponding. She has been very restless all night at times. The case is really very serious. Piles of rags have been saturated with the blood, besides what has been spit in the basin. Because of the restlessness and weakness a change was made to Ars.[30] every quarter hour and Hamamelis locally with cotton and lint compress. The latter seemed to have no effect on the bleeding; cannot get the compress firm enough. The strength is improved, also the restlessness, probably by the Ars., possibly from the time of the day.

At 11 A. M., Drs. A. Lippe and M. Macfarlan met me, and the latter, with our approval, packed around the gums with styptic cotton and raw cotton, making a firm mass between the gum and cheek. Dr. Lippe suggested Millefol. every half hour for six or

eight hours, to be followed, if necessary, by Carbo veg. The bleeding was controlled about forty-six hours from the start, but the plugs were left in till too offensive to remain longer. Just before we adopted the plugging a steady stream of hot water was thrown upon the gum from a rubber syringe. Its effect was decidedly good, though transient. Ice was not used.

When strong she went to Bellefonte and had chills again. In a few days was well. No chills since.

This was the first and only severe hæmorrhage, though she has had a tooth extracted from that jaw, and has had cuts on the hand since. Menses were always very free, amounting almost to a hæmorrhage. She has rheumatic swelling of knees, ankles and small joints. Father died at 61 of Bright's disease. Had bleeding piles. Mother died at 58 of pneumonia. Had previously had two hæmorrhages from the lungs.

A brother, after pneumonia, had hæmorrhages from the lungs, but died in a cataleptic fit.

Maternal grandfather very healthy, died of paralysis.

Maternal grandmother and paternal grandmother both died of consumption. No further record.

This case was either cured of the diathesis by the treatment, or, as I think, never had hæmophilia, but suffered from vitiated blood, the result of the medicines used and of the malaria. Yet it shows that such conditions are not to be treated lightly, as they may be very dangerous. Both these cases of hæmorrhage from the mouth show the value of local measures, and especially of the compress when firmly applied. The treatment of hæmorrhages of this tract should be both constitutional and local when local means can reach the trouble. The latter are the application of *cold* or *heat*, or of *styptics* to the parts, the compress with or without styptics, acupressure, and, in extreme cases, the ligature or actual cautery. Even in bleeding from the stomach, ice or salt may be swallowed, also alum. Oil of turpentine or ergot may also be used, though these act more specifically than as styptics. Any of these means may be applied to the rectum or anus also, or the per-sulphate of iron may be used.

Rest and freedom from excitement are, of course, to be insisted upon. If the flow is from the stomach, abstinence from all food may

be necessary for a time, and nourishing injections into the bowel must be used. For faintness the horizontal position, with the head low, raising the limbs to a perpendicular position, or the use of Esmarch's bandage to drive the blood to the central organs. Inhalations of ammonia or ether are preferable to giving brandy in stomach cases, though the latter may be used hypodermically.

As the number of remedies having hæmorrhage in their curative range of action is very large, and any one of them may be useful if called for by characteristic indications, I can only refer to some of those most often useful.

Bleeding from the gums: Ars., Calc. c., Carbo v., Caust., Merc., Nat. m., Phos., Phos. ac., Puls., Rhus tox., Nit. ac., Staph.

Hæmatemesis: Arnica from an injury, Ars. dark blood and same in stool, Ipecac when there is much nausea. China after exhaustion from loss of blood. Carbo v. in prostration after China or Ars. has failed. Nux v. when there is gastralgia and abdominal plethora. Acon. with full pulse. Also Erig., Ferr., Ham., Lach., Phos., Phos. ac., and Secale as indicated.

Hæmorrhage from the bowels: Nit. ac., Sulph. ac., Mur. ac., Phos. ac., Ars., Phos., Carbo v., Ham., Ipec., China, Crocus, Sabina, Secale and Ferr. sulph.

T. S. Dunning, M. D.

UTERINE HÆMORRHAGE.

The subject of uterine hæmorrhage embraces such a vast field that it will be impossible, in our limited space, to do much more than refer you to our text books for thorough and careful treatises; but as it is frequently necessary, in its treatment, to be very prompt, both with medical and with mechanical means, it might be well to call attention to a few points. Uterine hæmorrhage can properly be divided into two general classes, viz: Menorrhagia or that hæmorrhage connected with the menstrual flow, and metrorrhagia, which embraces all other hæmorrhages from those parts. The first of these divisions can be sub-divided into functional, organic and sympathetic, and the latter into those dependent on the parturient state, the climacteric period and those occasioned by abnormal growths and general conditions when not connected with the men-

strual flow. In the menorrhagic sub-divisions, functional is increased quantity or frequency of the menstrual flow; organic is dependent on disorders of the sexual organs; and sympathetic is dependent on forms of general disease. The functional form, or increased action of this function, is generally caused by plethoric habits, in the blood itself, from debility, etc., and if not arrested it will soon cause an organic condition, which thus throws it into the second class. Organic menorrhagia occurs when the organ itself or its appendages become diseased, and from a simple congestion of those parts, probably caused from functional disorders we have the formation of ulcers, polypi, fibrous tumors, cancers, etc., the presence of which all more or less affect the menstrual flow, and in time may cause most alarming hæmorrhages. In sympathetic menorrhagia, the flow is in connection with some form of disease, such as typhus, cholera, acute inflammations, especially of the lungs, and other diseases: these hæmorrhages frequently are quite alarming, and must be arrested as quickly as possible, else the patient becomes too prostrated to cope with the disease under which she is laboring. The climacteric period also frequently causes this sympathetic menorrhagia, and as at that period in life the organic diseases are generally pretty well advanced, a menorrhagia, then, is to be dreaded more than at any other time. All these various conditions can be best studied from our text books, and the treatment selected accordingly, and it would be poor policy for a paper to be compiled from other authors and inflicted upon those who have the same chances of examining these authors as the writer. A few cases from actual practice would certainly be more acceptable and instructive.

Being called to see a case of violent hæmorrhage, it was found to be a plain case of menorrhagia. The blood was gushing from the patient in a frightful manner, bright red, no pain, patient emaciated and weak, and evidently in great danger of collapse. From the symptoms present I prescribed Ipecac, and at once inserted a tampon, with which the vagina was thoroughly packed, and left the patient feeling perfectly satisfied that everything had been done to insure her safety. Returned next day, when there was found to be a most horrible stench pervading the whole house, and patient was in an anxious state of mind from this condition; on removing the tampon, the

windows had to be raised, and it was a long time before the room was even bearable. The hæmorrhage began again immediately, but was not so active. Prescribed Ustilago, which almost immediately arrested it, to a certain extent, and in a short time it ceased altogether, and patient was convalescent. This case would naturally lead us to ask the cause, etc. A thorough examination showed there was no polypoid growth, no apparent congestion of the uterus or its appendages, no hæmorrhagic diathesis, but there was a general debility, etc., which appeared to relax the fibres of her system; hence the hæmorrhage and the flow being retarded by the tampon, caused the blood to become decomposed, thus producing the frightful stench. This blood condition, which was evidently venous blood, from its rapid decomposition, also accounts for the prompt action of Ustilago, which acts more especially upon the venous capillaries, and by this action, in this case, caused a cessation of the venous flow.

Case II. Was attacked with a sudden profuse hæmorrhage, which almost drained the patient before medical treatment could be procured; examination revealed a large cancerous growth within the cavity of the uterus, and one of the blood vessels having been invaded, the hæmorrhage was the result. In this case Secale and, later, China stopped the flow, especially as a large clot soon formed a natural tampon, but the loss of blood had been so excessive as to cause a collapsed condition of the whole system, so much so, that nothing could be retained in the stomach, even a teaspoonful of water would be ejected immediately; the violent retching would dislodge the clot, and thus weaken her still more. Hours of patient and careful treatment seemed of but little benefit, until milk was given with equal parts of lime water, when the stomach became more settled, food was gradually administered, and finally the patient became apparently as strong and healthy as ever; but the presence of the cancer makes it only a matter of time when she will be beyond all help.

Case III. A young lady having decided phthisis, began menstruating at the age of fourteen. Menses were irregular, dark and quite profuse, but as the lung trouble increased, menses became somewhat irregular and finally stopped for five months, when, as the patient was becoming debilitated, there suddenly appeared an

alarming hæmorrhage, of dark, clotted blood, which quickly reduced the patient very much. Upon being summoned, administered Sabina, which checked the flow, and she gradually gained strength, then gave constitutional medicine, principally Kali phos., under which she rapidly improved and her friends thought she would soon be well again, but at present writing, menses have ceased again, system is rapidly running down and a fatal termination seems to be impending.

Our authors recommend numerous methods of procedure in cases of flooding connected with child birth. Such as applications of ice and cold water, injections of hot water, &c., with numerous other expedients, all of which may have their good qualities, but as the emergency sometimes is so great that we may lose our patient before these things can be procured, especially as it might cause nervousness and excitement for us to apparently prepare ourselves beforehand by ordering these things to be at hand. It is pleasant to be able to think that in many cases the proper remedy will help us out by using only such manipulations with the hand as ordinary common sense will dictate. As examples take the following two cases of this form of metrorrhagia in actual practice. First case had a quick and apparently good delivery, but after removal of placenta a sudden gasping of the patient disclosed the fact that she was flooding. The blood gushed as from a hydrant, bright red, and threatening death in a few minutes. Fortunately had previously mixed some Ipecac in water which the nurse was directed to give the patient. Inserted one hand into the uterus and with the other hand on the abdomen succeeded in bringing on contractions which arrested the hæmorrhage and the patient recovered. Subsequent labors have been free from hæmorrhages.

Second case. Some months before delivery had her feet slip on the icy pavement when she sat violently down, which gave her quite a shock, and her symptoms caused me to fear an attachment of the placenta. After delivery of the child she had strong contractive pains which, failing to expel the placenta, caused an hour-glass contraction; this ruptured the placenta, and an alarming hæmorrhage took place that drained the patient considerably. Gave China but she fainted several times and could keep life in her only by administering brandy and milk in spoonful doses every

minute. Inserted the hand into the uterus up to the seat of contraction and by insinuating first one finger, then another, and so on, finally passsed the contraction and found the placenta to be attached to the very fundus of the uterus; gradually peeled this off and finally succeeded in removing it, at the expense of an almost crushed hand, but the hæmorrhage ceased. The debilitated patient gradually recovered her strength and made a happy recovery. Cases of abortion, premature births, placenta prævia, etc., all of which cause more or less hæmorrhage, can best be studied from our authors who have had most experience in these cases and who have given their attention to their study and treatment and although I have had a number of cases of some of these forms of hæmorrhages, there has been nothing sufficiently marked to warrant them being inflicted upon your attention. In cases of metrorrhagia from cancer, polypoid and other growths, &c., we have a foreign substance causing the hæmorrhages, and said substance must be removed before we can hope for final recovery. We should, therefore, direct our medicines to the constitutional treatment, and by building up the general systems of our patients they will be better able to withstand the mechanical means which we may be called upon to use, and we may not only have them recover from the hæmorrhages and their causes, but also remove the predisposition to such growths, and thus save life and suffering. In closing I will state that a thorough knowledge of our materia medica, a thorough analysis of our cases and their causes, and of the action of our drugs, so as to apply them properly, will rob uterine hæmorrhages of considerable of their terrors. All the cases that have been recited could be analyzed, and the conditions of the patients and of the organs from which the hæmorrhage came being perfectly understood their cessation could be satisfactorily accounted for; but the paper is entirely too long already, and your time and attention must not be imposed upon any more.

GEO. W. SMITH, M. D.

CLINICAL CASES.

BY Z. T. MILLER, M. D., PITTSBURGH.

PARAMETRITIS.—Pregnant approaching the third month; fell down from the lower three cellar steps. Could give no account

of the fall, but had a slight bruise on the sacral region. Several days passed when hæmorrhage set in and a miscarriage predicted. Sabina controlled the hæmorrhage completely as also the pain. Patient had remained quiet in bed, but the fœtus was discharged the third day following the hæmorrhage. I did not see it, but everything was reported to have come away, and patient doing well. During the next four weeks she had two hæmorrhages, at intervals of ten days; they were not alarming; I told the husband that some of the placenta must have remained, but he thonght not. About four weeks from the time the fœtus was discharged, she awoke suddenly about 4 A. M., and screamed that she "was flooding," and fainted every time she was raised, pulse rapid, face very pale. I was summoned hastily—a distance of seven miles—and found, what I had suspected, a retained placenta. I removed what I could reach, which amounted to a piece about as large as a small egg. The hæmorrhage was passive, never had been active, and her collapsed condition was evidently due to fright. I tamponed the vagina and left it for an hour, after which I removed the balance of the placenta then in reach which amounted to the size of another small egg. There now ensued the usual amount of detritic wasting, such as I have seen many times. No fever, no tenderness, but the most persistent gagging and vomiting I have ever met. I think we "spoiled" her stomach by too much "Duffy's malt whiskey," and numerous other resussitants, administered by loving friends and her brother an "old school" student. However, the case progressed, fainting, retching, vomiting, etc., despite Bry., Ars., Ipec., Colch. Still no fever, no tenderness, but rapid pulse, 120. One morning, a slight chill preceded a temperature of $106\frac{1}{2}°$, pulse 120; by night the temperature went down to 99°, next day rose to $105\frac{1}{2}°$, with evening fall to 100°. From this time on for three months, the temperature varied from 100° to 99°, so we dismiss that part of it. The pulse remained 120 throughout; we dismiss that also. Shortly after the rise of temperature, the hypogastrium became tender, the womb fixed in the pelvis and large, irregular-shaped indurations began to appear in the groin, more particularly the right, filling, almost completely, the iliac fossa. Tympanitis, involuntary urine and feces, mild delirium, characterized by insomnia and loss of power to carry the sequence of events;

that is, she thought occurrences were of to-day that happened several days past. Hyos.^{6x} did not do what was wanted, and not until Hyos.^{1x}, suggested by J. B. McClelland, M.D., was given, did there seem to be a clearing up of mental symptoms. The indurations melted with astonishing rapidity under Hepar. s.^{3x} trit. This case continued over four months from time of miscarriage until she was able to walk about. She was under daily observation for nearly ten weeks. The features of the case were much complicated by hysteria and fear and what seemed to me a disposition on part of patient to magnify her condition. Her persistent vomiting and gagging, with fainting or rising, *did not* yield to Bry.^{3} 30 or 200. Lach.^{200} removed a feeling of intolerance for anything about the neck or abdomen. No abscesses formed, but there was, for several days, a discharge of pus from the endometrium.

This was a case of parametritis, caused by setting the patient on a cold bed-pan.

Zeimssen has the best article on this trouble. When the placenta was removed there was not the least sign of putresence, nor did there appear to be any clearly defined septic symptoms.

A woman said she was pregnant seven months, but her size did not indicate it. She called me and said she had sharp pains and something came out between her legs. She was not mistaken, for there was a sack the size of a small pig's bladder filled with fluid hanging from the vaginal orifice; there was nothing in it but fluid. Exploring further, I found an arm grasped by the os closely. She had regular pains. In two hours saw patient again. Conditions same. At 1 A. M. was called. The pains had been very severe and ceased suddenly. I found the sack still intact; in the vagina lay the fœtus, which I pulled out, the placenta coming at the same time. There was the sack containing the child and amniotic fluid, with the placenta all intact. I do not meddle with miscarriages when there is no hæmorrhage.

May 30, short, stout, good-natured blonde came, complaining of a train of symptoms, for which Apis^{12}. was given. Symptoms were: sweat in the small of back, pain in both groins, worse moving or breathing; burns in pit of stomach, relieved by eating; hard swelling of legs, limbs heavy, worse before changes; swelling about eyes; urine scanty.

June 11—No better; "feet buzz like a bee-hive," was what she said. Red, itching spots on face, but legs feel lighter. Sac. lac.

June 22.—"The last medicine did me a world of good," was what she said; feels lighter and can do her work without any trouble. One dose Apis.^{12} and Sac. lac.

The reported verification of the diarrhœa symptoms of Thuya can be found in the *Homœopathic Physician* of April. The ^{60m} always relieved when the lower failed. Carbo veg.^{76m} relieved incessant belching with burning in stomach. Patient was loud in her commendation, but it was not permanent. Coloc.^{100m} caused a patient to "change easier than she had for fifteen years," notwithstanding she had taken Coloc.^{3} with indifferent benefit.

These preparations came from Dr. Macfarlan, of Philadelphia.

Rhus tox^{100m}.—Lady with face and hands poisoned while gathering blackberries. The face presented a perfect picture of facial erysipelas of the vesicular type, the hands and forearm were covered with patches of vesicles. Sang.^{3} was given for two days, with the case going worse. With fear at heart I gave Rhus^{100m}, and the decrease in twelve hours astonished us all. I do not consider this a reliable verification, but it gratified the patient; next time I will give Rhus^{100m} first and something else later if necessary.

Lycopodium 30th, 200th. Boy five years, dark skin, had high fever and complained of sore throat. Both tonsils swelled, worse right side, covered with a gray, thin film, breath offensive, pain when swallowing; two very sore toes. Lycop^{30}.

Second day.—Fever less, swelling greater and perceptible externally, worse right; membranes same in area, but thicker and white; breath very offensive, tongue coated, or rather, furred and yellow brown; still pains to swallow. Lycop.^{200} in water; gargle with hot water.

Third day.—Toes not so sore; swelling same; membranes turning black, softening; still very painful to swallow. Same.

Fourth day.—Tonsils cleaning; less pain; a small patch on uvula; child stronger; disposed to eat. Lycop.^{200}.

Fifth day.—Throat almost clear. Discharged.

CLINICAL GLEANINGS.

BY A. P. BOWIE, M. D., UNIONTOWN.

The field of clinical medicine is so large that I can only offer a few gleanings from experience, which I hope will be of interest to the members of our Society; for, to my mind, a carefully written record of cases as they occur in practice, and a report of the same, will furnish material for a much needed work—a Clinical Materia Medica, and thus the tares in our materia medica may be rooted while the wheat remains.

So many of our remedies have been repeatedly beneficial in practice that I shall only repeat such cases as are not often met with or remedies that need confirmation.

Three Cases Cured with Hecla lava[30].—This remedy was first brought to my notice by an article in the Transactions of the American Institute of Homœopathy for 1870, and was there recommended for complaints of the maxillæ, and as there are no provings of the drug I report the following cases showing its clinical value:

Mrs. A. After the extraction of a molar tooth she has had violent pain in the upper jaw which no domestic remedies will relieve. Jaw is sore and swelled, and is painful to the touch. ℞ Hecla Lava[30] in water, a dose every half hour, relieved the pain entirely in a short time.

John —, a colored lad, aged 15, had a sore tooth which was extracted, and ever since then there has been an enlargement of the lower jaw, near the cavity of the tooth, which has grown now to the size of a hickory nut, and can be seen very plainly as the cheek bulges out, and it is hard to the touch.

It has now lasted for several months and seems to be growing larger. ℞ Hecla lava[30], one powder night and morning, removed the growth in one month's time. But the most remarkable effects of this remedy were obtained in the case of my brother, who for several years had been effected with a growth of a polypoid character, and which commenced in the antrum Highmoriana, and from thence encroached upon the adjacent structures so as to deform the face, forcing the eyeball upwards and everting the lid,

and obstructing the nostrils; and downward into the mouth, so that breathing and mastication were both seriously impeded. The concomitant symptoms were epistaxis, headache and difficult swallowing. After various remedies were used in the case with no effect, I prescribed Hecla lava[30] in infrequent doses, and with the result of curing the tumor entirely. Of course, some deformity remains, but the growth has entirely disappeared, and now after the lapse of several years there has been no return.

Clinical Symptoms of Macrotin.—A patient for whom I prescribed Macrotin[3x] in tablets, reports the following new symptoms which she thinks are due to the remedy:

Cannot sleep for thinking. Head feels full. While lying down at night the pillow seems to slip away from her head. Vertigo, with inclination to fall to right; weakness in right arm; can hardly raise it. These symptoms lasted for several days.

Shortly afterwards a patient complained of full feeling in head, with vertigo and weakness in right arm, and for which I gave her Macrotin[2x] with prompt relief.

A patient for whom I prescribed Aconitum[2x] for facial neuralgia had a violent fit of laughing every time the medicine was taken, with prompt relief of the pain.

Rhus tox. in Dysentery.—In a recent epidemic of dysentery where the tenesmic stools were followed by involuntary discharges from the bowels, Rhus tox. was the remedy.

A few cases of typhoid fever occurred at the same time and for which Rhus proved to be the remedy.

Strontia Constipation.—Mrs. L. After a tedious labor, the bowels were obstinately constipated and for which several remedies were ineffectually prescribed, and for which, enema did no good. A careful examination revealed the following symptoms:

Stools large and hard expelled with great effort, followed by great pain in anus of a burning character and lasting for a long time, and obliging her to lie down. Anus violently contracted after stool. Complains of coldness in spots in calves of legs. Strontia carb[6]. was prescribed with entire relief.

CASES SHOWING THE APPARENTLY CONTAGIOUS NATURE OF MOLLUSCUM EPITHELIALE.

BY EDWARD M. GRAMM, M. D., OF PHILADELPHIA.

The disease under consideration is of frequent occurrence in England, and was first described by Bateman as molluscum contagiosum, he believing that it is communicable from individual to individual. English physicians, as a class, believe in its contagious nature, but on the continent of Europe and in this country, this theory is discarded or held as not having been proven.

Whether its point of departure is in the epithelial or sebaceous structures is also disputed, many and eminent authorities having arrayed themselves *pro* and *con.*

The salient features of the malady are as follows: The lesions are discrete and are non-inflammatory in appearance. They consist of much elevated, superficial, globular tubercles, at the centre of which a dark elevated or depressed point can be seen. They vary in color, but are generally of the normal hue of the skin or are pinkish, and remind the observer of a solid body surrounded by a portion of much stretched normal skin, giving them a glossy or waxy appearance. They are oftenest seen in children and most commonly on the face, especially on the eyelids and about the mouth, although other localities are not exempt from them. The palms and soles are, however, never affected.

As a rule, the lesions increase in size rather slowly, and, after a time, become inflamed, ulcerate slightly, drop off and do not recur. The period between their development and disintegration is a variable one, but during the whole of it, no subjective symptoms are experienced.

This concludes the resumé of the affection, and I will now give the cases in the order of their occurrence. The three mothers, in whom or in whose families the disease manifested itself, were sisters accustomed to visit each other frequently, and even lived together a portion of the time that this history embraces.

Mrs. M., æt. 24 at the time she contracted the disease about five years ago, had one molluscous tubercle on an upper eyelid. It remained about three weeks and then became slightly inflamed, ulcerated aud fell off.

Mattie M., the child of the above, was between a year and a half and two years old when the face and vulva became the site of the manifestations of the disease, between fifteen and twenty months having elapsed since the mother first noticed the existence of the disease in herself. A spontaneous cure terminated this case.

Elsie P., æt. 7 months, when her chin, outer angle of both eyes, corners of the mouth, right side of the face, front of the chest, back and genitalia had numerous tubercles develop upon them. They made their appearance eighteen months after manifesting themselves in the last patient, and persisted until cured by homœopathic remedies. Of this I will speak farther on.

Mrs. P., æt. 30, the mother of the preceding and succeeding patients, had the disease develop in herself a few weeks after Elsie's appeared. A spontaneous cure rid her of the lesions.

Alice P., æt. 5½ years, was attacked, in the face, by the malady one year after her mother and sister, and was finally cured by internal medication.

A child of the sister of Mrs. M. and Mrs. P. is said to have suffered from lesions identical with those seen in the P. children, but I was unable to get an accurate history of the case.

To recapitulate, patient number two was attacked between fifteen and twenty months after patient number one, to be followed by patient number three, eighteen months later. In a few weeks, patient number four had the disease appear in her, and one year later, it broke out in patient number five. During the time that the disease affected some of the foregoing, patient number six also, presumably, suffered from the same malady.

I determined to report these cases, that they might go on record, but I do not wish to be understood as upholding any theory concerning them, as they are the only instances that I have been enabled to meet with in a dispensary practice of more than three years, which demonstrates the rarity of the affection in this country.

This paper, however, would be incomplete to us as homœopathic physicians without a reference to the treatment of cases numbers three and five, which I had the good fortune to have under my care. Case number three was an aggravated one, and had lasted a year and a half, but was cured in about three weeks by Pulsat.*0*, the temperament and disposition of the child being

the indicating symptoms. The subjective symptoms were nil.

Case number five had lasted about six months, and was cured in three weeks by Silic.[30], the indicating symptoms being a tendency to rawness between the toes, cold feet and inability to withstand cold.

Kippax recommends Silica and Teucrium as the most frequently indicated remedies, and Bryon., Bromine, Calcar. ars., Kali iod., Lycop. and Natrum mur. as being useful; but there is no doubt about it that the most rapid and permanent cure of any disease of the skin or of any other portion of the body can only be accomplished by a strict and thorough individualization.

NOTES OF INTERESTING CLINICAL CASES.

BY CHARLES MOHR, M. D., PHILADELPHIA, PA.

(*a.*) Chronic Bright's Disease.—My case-book contains notes of two interesting cases of Bright's disease in which I observed, during the uræmia prior to death, a symptom I had not before met with, nor which, so far as I know, has been recorded in any published treatise. The first case was that of a woman, aged 30 years, who died January 15th, 1886. Two days previous to death the urine was entirely suppressed, the catheter failing to remove more than a few drops from the bladder during the whole forty-eight hours. This period was attended with copious general sweats, drying soon, and leaving the cutaneous surface, from head to foot, covered with crystals of salt. The woman literally looked, after each sweat, as if she had been salted down.

The second case was that of a man, aged 34 years, who died May 16th, 1886, in whom a similar phenomenon was witnessed, although the secretion of urine was not so entirely suppressed, and the sweat-solids were only deposited upon the skin of the abdomen.

(*b.*) Sciatica.—Of some severe cases of sciatica I recall two of considerable interest. Case I.—A shoemaker had had a right sided sciatica with lameness for eight years. Various treatments had been employed unavailingly. He finally applied for treatment at the clinics of the Hahnemann College, his position, while awaiting attention,

suggesting the curative remedy. He was sitting on a chair, leaning forward, and pressing his hands firmly into the abdomen, as if to relieve pain. Investigation then revealed the fact that prior to each exaccerbation of the sciatica,—tenderness along the track of the nerve and lameness were constantly experienced,—he would have a spell of severe colic, only relieved by the position in which I saw him. A few powders of Colocynthis^{8000}, were surprisingly quick and effectual in affording relief. Three years later, he came to me with a return of his neuralgia, attended by the same colic, when Colocynthis^{3x}, relieved him as quickly and effectually as the higher potency had done. Eight years later, I treated this patient for a slight gastric disturbance, at which time he told me that he had been entirely free from colic and sciatica since I last prescribed Colocynthis^{3x}.

Case II.—A young, married woman, of good social standing, had sciatica three years. The exacerbations became more and more severe, until she was compelled to seek her bed, to which she had been confined some weeks when I was called to see her. The painful leg, the left, was atrophied. I treated her several weeks without any effect, and was about to give up the case, as my predecessors (two allopaths and two homœopaths) had done, in disgust, when I concluded to make one last, desperate effort to find a remedy. I investigated the case *de novo*, inquiring into every detail of her ailments since childhood, into her habits of life, etc., and finally, not without tears and blushes of shame, she admitted having contracted a gonorrhœa which had been treated and cured (?) by her then medical attendant with injections. *The first twinges of her sciatica were felt when she was pronounced cured of the venereal disease.* My course seemed clear then, and on August 3rd, 1883, I gave her Thuja^{3} with relief of pain in a few days. On August 17th, the remedy was repeated, and again on August 27th, the result being a complete cure. I saw this patient at Atlantic City this summer in most excellent health.

(*c.*) Coccygodynia.—Neuralgia of the coccygeal nerves often proves a troublesome affection, especially as I have found it in subjects of a rheumatic tendency. I merely, in this place, wish to call attention to *Fluoric acid* as a remedy. I have found it to cure men and women, when there was excessive aching in the region

of the coccyx, and moreover in cases where Rhus tox, Ruta, and Silica seemed indicated, doing some good, perhaps, but not effecting a cure.

(*d.*) CHOREA.—An interesting case was that of one of our city physicians, who consulted me June 2, 1884. His case is best described in his own words: "When little past twenty-one years of age I found myself indeed a wreck, due to two years of hard labor, coupled with great mental anxiety and insufficient sleep. Immediately after this break-down I suffered from heat-stroke. Shortly after the general break-down, and aggravated after the heat-stroke, I noticed the following symptoms: great exhaustion after physical or mental effort, depression of spirits, inability to co-ordinate muscular movements, particularly of the lower extremities. If I observed persons watching me, my movements would become exceedingly awkward, and I would almost lose control of myself. Have never been troubled with seminal emissions to any extent. Sexual organs slightly impaired, but not to an extent to occasion any inconvenience. Bowels always regular. From the time of break-down, twelve years ago, have lived a very systematic life, husbanding my vitality in every way possible, but the awkward, choreic movements were getting worse and worse until you prescribed for me, when they seemed to yield almost magically to the treatment."

The remedy I employed in this confrere's case was *Veratrum viride*[1], an inconsiderable number of doses only being required.

(*e.*) TYPHOID FEVER.—I have a record of several cases treated and cured with *Belladonna*, a remedy considered by some as inadmissable in enteric fever, but which I have found extremely useful, even in grave cases, as the two I here note, show.

CASE I.—Mrs. M., æt. 37 years, had typhoid fever in January, 1883. Was four months pregnant at the time. For three successive nights, was wildly delirious; would cry out suddenly as if in pain, saying "my back will break," and after making expulsive efforts, would declare that her baby would soon be born. Belladonna[3] controlled the fever and lessened the delirium as soon as it was given. The patient made a good recovery and went to term, giving birth to a healthy female child.

CASE II.—Mrs. B., æt. 26 years, who had given birth to a first

child on September 30th, 1885, began to sicken with enteric fever in the beginning of the following November. On November 20th, the fever had reached its acme, with an evening temperature of 104° F. The case progressed as most cases of pronounced typhoids do, until December 20th, when the temperature registered normal in the evening for the first time. Convalescence seemed well-established, the temperature varying from 96° to 98° F. in the morning and from 97.6° to 98.4° F. in the evening until December 30th, when she complained of chilliness and malaise, with a morning temperature of 99° F. and an evening temperature of 99.8° F. On the succeeding two days, the temperature was as follows: December 31st, morning 100° F., evening 102.2° F.; January 1st, morning 100.6° F., evening 103° F. Later in the evening of January 1st she cried out suddenly with pain, her face betokened great anxiety, and was beaded with sweat, and her nurse believed her dying. I was summoned, reaching the house about 1 A. M., when I found the abdomen distended, tense and resistant, respirations 46, pulse 140 and weak, symptoms certainly simulating perforation. Prescribed *Belladonna*[1], which was followed in a few hours by improvement in the respiration and pulse, and although the temperature twenty hours later was 104.8° F., and the abdomen was still tense, and now quite tender to even slight touch, I continued the remedy, and had the gratification of seeing the case improve day by day, re-convalescence beginning January 16th, when the temperature, for the first time since the relapse, fell to the normal point. This patient, except to suffer with some deafness—the deafness during her fever, by the way, being complete—has made a good recovery. I found much difficulty, however, during her convalescence, to get her to take food, so that she was extremely emaciated for weeks, and I succeeded in nourishing her first by the use of Wells, Richardson & Co.'s Lactated Food, which I found applicable also to her babe, the little thing threatening to succumb to marasmus.

(*f.*) Pertussis.—On July 6th, 1882, I was called to see Virgilio G., son of Dr. G. This child had been suffering with pertussis for five weeks. Nothing of an alarming character was observed by Dr. G. about the sickness of the little fellow until the night of June 28th, when he began to have fainting spells after each paroxysm

of cough. The father then gave *Bryonia 0* in water every two hours without result. Patient now shows uncontrollable temper, and his anger gives rise to frequent paroxysms of cough, with difficulty of breathing before and after the paroxysm. *Anacardium*^{3x} was given in water every two hours for two days without effect. Patient emaciating fast, cough paroxysms of longer duration, during which he becomes black in the face and rigid. *Cuprum*^{3x} a dose every few hours for two days was also ineffectual. From this time until I was summoned, the child was very sick, for in addition to the continuous paroxysms of cough and the resultant vomiting, there were extreme debility and emaciation, and there were chills in forenoon, with a decided increase in temperature between 3 and 4 o'clock P. M. I found the tongue thickly coated, bad smell from the mouth, sordes on teeth, no appetite for food, but great craving for sugar or candy, can retain nothing if forced to eat, cough paroxysms number twelve to fifteen in twenty-four hours, worse after midnight, and is unable to sleep. The physical signs were those of lung disintegration. Prognosis unfavorable. Prescribed *Argentum nitricum*^{6}, of which he received a powder at 7 P. M., and a second at 10 P. M. On the following day, July 7th, I was surprised and pleased to find that he had slept from 11 P. M. after the second powder until 5 A. M. continuously. Encouraged by this result, I gave three more powders of *Arg. nitr.*^{6} at intervals of four hours; these were followed by a still more decided improvement, which continued until health was fully restored. After he could take food, cod liver oil, was prescribed, and continued during the fall and winter.

(*g.*) Progressive Anæmia.—Some years ago, I treated a case of anæmia, which threatened to prove pernicious, and which I refer to here only to show the value of *Argentum nitricum* in mal-nutrition when there is a great craving for sweets. The case was that of a middle-aged, unmarried woman, who was amenorrhœic, had a bloodless face, suffered with fever paroxysms, and was losing flesh to an alarming extent. Her physician, an allopath, during a period of eight months had exhausted all his measures for relief, and then consented to have her apply to a homœopathist. When consulted, I learned that she had great hunger for candy or sugar, loathed all other food, and was satisfied only when her one craving was satis-

fied, although the sweets showed a tendency to provoke diarrhœa. A careful examination revealed no organic disease, and hence I gave *Argentum nitr.*[6], with every assurance that it would do good, and I was not mistaken, for week after week witnessed improvement. *Pulsat.* re-established the menses, and in a few months her lost flesh had been regained, much to the astonishment of the allopath, who declared there must be something in homœopathy after all.

(*h.*) Sexual Debility.—Among my patients have been many young men, who have been worried to the verge of despair by the belief that they had *spermatorrhœa*, because, forsooth, some doctor had found spermatzoa in the urine, a perfectly normal condition in most cases. Others have been driven to despair, almost, because the results of early masturbation had been entirely too much magnified. Some have been made unhappy, and perhaps wrecked morally, by the mischievous advice sometimes given young men, even by physicians, to try their sexual ability, if there had been any question about it, by intercourse, advice resulting many times in the degradation of a young, and heretofore innocent woman, or in the besmirching of a young man's physical being, as well as of his morality, by contracting a loathsome disease, if, as is quite likely, he tries his powers on a harlot. I am led to these reflections because quite recently a young school teacher, aged 22 years, was sent to me by his friend and physician for advice and treatment, his story being that when quite young he had masturbated; when 16 years old, the reading of a book—one of that class of pernicious trash on sexual subjects with which the market is flooded—made him fear that his former bad habit had permanently injured him, and induced him to consult a physician, who gave him Phosphorus pills, and advised him, after a few weeks, to seek out a woman with whom to try if his supposed sexual disability had been removed by the treatment! Failure was the result, as one might well expect, but his medical *abuser* continued the same hellish advice. Again sexual intercourse was attempted, and again proved a failure. Almost despairing, the young man drifted from one doctor to another to get advice little worth having, or the treatment with aphrodisiacs and the same advice to test his capabilities he had got in the first place. Placing himself last under the care of a homœopathist, who treated him

for some months without any result, he had about come to the conclusion that his case was a hopeless one, and with extreme solicitude came to me with a note from this physician, telling me what remedies had been used, and asking me to help the case if it were possible. I found the patient a very intelligent young man, and fortunately, the bad advice of some former physicians had not robbed him of his innate sense of decency. I inquired closely into his habits, and found that for several months past they had been perfectly correct. When I inquired into his diet I found the key to his whole trouble—an inordinate desire for table salt, which he would eat in large quantities. I therefore issued an edict against salt, encouraged him all I could, advised him to read Acton's work on *The Reproductive Organs* (a book every young man should read), and prescribed twelve powders of *Phosphorus*[3], one to be taken night and morning. I cautioned him, as I do all such unmarried young men, against seeking sexual indulgence, reminding him that if he had an emission or two every few weeks, without being followed by languor or other bad feeling, and if he had morning erections, he could rest assured that no test of sexual ability was required. The result of treatment thus far is shown by this letter, dated September 21st: "Please send me further treatment. Have had one emission with dream, which is unusual, not having occurred in two years. Have had several strong erections before arising in the morning, but not two days in succession. On the whole, there is decided improvement. I have read Acton with great profit. The work is that of a master." Now I feel assured that on *placebo* the young man will continue to improve until he has thoroughly recovered.

DISCUSSION.

Dr. Aug. Korndœrfer said that, in listening to the paper read by Dr. Martin, he was much interested in his relation of the case treated by Manganum metallicum. Manganum aceticum is generally considered to be the most active preparation of Manganese, which we usually employ, its action being very similar to the metallicum. The one symptom that Dr. Martin mentioned, relief

from lying down is not the only key-note of the remedy. One which Dr. Korndœrfer had used with admirable results was: rheumatic pains, with localized erythematous spots, which are extremely painful, lasting sometimes for two, three or four hours, and sometimes for days. These spots vary in size from that of a pin to that of a dollar. They do not appear in any specialized location. They are found over various portions of the limbs, but more frequently over the forearms and hands. These spots evidently involve the skin, consisting probably of a dermato-cellulitis. This symptom, accompanied by the cough, would, in lung cases, certainly render the remedy sure in its action.

In regard to the manner of reporting cases in clinical medicine, Dr. Korndœrfer said that, in a large majority of the cases, there was but little stress laid on the homœopathic curative treatment. He hoped that the profession would lay more stress on the key-note symptoms indicating drugs, and not on long-drawn out reports of cases. The bringing forward of characteristics of remedies in our meetings is becoming almost obsolete. Another thing is the growing tendency in our society meetings, toward the introduction of palliative measures instead of the curative treatment. Dr. Korndœrfer then exhibited a little medicine case that he had brought with him for the purpose of presenting it to the College to be placed in the museum. The case was gotten up in imitation of a book, and the vials it contained were extremely small. It was stocked with drugs in the thirtieth potency. It was this case, Dr. Korndœrfer said, that had suggested to him the propriety of his remarks. There is a tendency in our school to deprecate small doses as though homœopathy had been built up by big doses instead of the little ones. It was the little doses that won the field for us. The case which he exhibited was a domestic case, and was given to one of Dr. Korndœrfer's patients, many years ago, by old Dr. Jeanes, who gave us so many grand characteristics, so many great central symptoms of our remedies. He was not ashamed of the little doses. The bottles in the case are so small that the patient could readily swallow them entire. Dr. Jeanes made the family, to whom he gave this medicine case, strong homœopathists in all its branches.

Dr. Korndœrfer expressed the hope that the time would come

ERRATA.

Page 164 line 5 from the top for "pin" read "pea."

Page 164 line 8 from the top, beginning, with "evidently" and lines 9, 10 and 11, should be amended to read, "These spots appear to involve the skin and deeper tissues, at times, so severely as to resemble a dermato-cellulitis. This symptom he had found very characteristic in lung cases accompanied by rheumatoid pains."

Page 165 line 8 from the top, insert "often" after physicians."

Page 165 line 15 from the top, for "secured" read "was led to secure."

Page 165 line 18 from the top, after "Korndœrfer," substitute "apologized for consuming," instead of "said that he did not feel that he had wasted."

Page 165 line 25 from the top, for "introduction" read "advancement."

Page 165 line 1 from the bottom, drop the "in."

Page 165 line 1 from the bottom, for "as a" read "to be."

Page 166 line 1 from the top, for "fraud" read "false."

Page 166 line 2 from the top, cross out all after "overthrow."

Page 166 line 16 from the top, for "afternoon" read "evening."

when physicians will give us more characteristics than they are doing now. He had brought this little case to our college museum simply to show how it was that we won our battles. That case was gotten up in Germany when it was an offence to practice homœopathy. The cases of homœopathic medicine were made in imitation of books; thus they could rest on the shelves of a bookcase without any danger of detection. At that time, homœopathic physicians practiced on the border line between two districts. When the officers of one district entered the front door, the physician escaped by stepping out the back door into the other. When homœopathy gained its most brilliant victories, physicians were using these little cases containing these little globules. Dr. Jeanes was one of the men who established the Homœopathic College of Pennsylvania. He was the man through whom the Hon. Charles Brown secured the charter for the original institution. He was the man who was instrumental in making many of us physicians. That man cured thousands of patients in the years of his practice. In conclusion, Dr. Korndœrfer said that he did not feel that he had wasted the time of the society in considering this matter.

Dr. David Cowley asked if there were any confirmations with the microscope of the efficacy of these small doses.

Dr. Korndœrfer said that, to Dr. Cowley's question, he would make the same reply as was once made by old Lawyer Brown. In 1849, perhaps earlier than that, a meeting was held at the office of Dr. Hering, to advise means for the introduction of homœopathy. A number of patrons of the system were present, and among them was Lawyer Brown. The lawyer never said a word until his opinion was asked by Dr. Hering, when he replied: "Gentlemen, cure your patients, you need no other advertisement; failing in that, all other things will do but little good." So, Dr. Korndœrfer said, the cure of cases is worth more than all the investigations with the microscope. The microscope tells us a truth, but it tells us an uncertain truth. It tells us of the character of pathological products. There it is invaluable. It tells us that in given triturations, it fails to discern medicine. *It tells us that it fails.* It does not tell us that there is no medicine there; it does not tell us that there is no power of sub-division. The microscope has been misleading, because it has led thousands to believe in the dynamic theory as a

fraud, or to believe in it as a theory that is standing on the brink of overthrow, as a theory that is not held as established by many. When the microscope is applied to the examination of our drug attenuations, it is wrongly used; the only instrument that we can apply here is the human organism. The speaker then proceeded to make a few remarks on hæmorrhage. He once treated a case to which he would call the attention of the Society. A gentleman occupied in the purchasing department of a large business learned, very unexpectedly, from his partner that his business was bankrupt. The shock was so great that he became greatly excited, rushed up and down stairs once or twice, and then into the parlor, when he had the most distressing attack of hæmatemesis that Dr. Korndœrfer ever attended. The blood clot on the floor covered a space of a square yard. He prescribed for the case, and the hæmorrhage was controlled without the use of iron or other styptic remedies. He had several hæmorrhages in the course of the afternoon, but no severe ones after taking the medicine. Because of the pale face, utter prostration, with coldness, almost Hippocratic appearance of the face, China was given. According to Dr. Hering's suggestion that China in these cases was most efficacious in the mother tincture, he (Dr. Korndœrfer) put a few drops of that preparation in a glass one-half full of water, and had the patient take of it every five minutes. It was astonishing to see how quickly it relieved. Now, another peculiarity of this case was that it illustrated most thoroughly the "Hahnemannian alternation" (which is not alternation of the routine type). China was given with relief. Shortly afterwards the patient developed the most intense nausea, with paleness of the face and blueness of the mouth. These symptoms pointed to Ipecac.; so that remedy was given in the thirtieth potency, also with prompt, good result. About six or eight hours after that, there came a dark venous hæmorrhage from the stomach, accompanied by great soreness in the region of the stomach, with sore feeling all over the body. Hamamelis, low, was given. Entire improvement of all the soreness followed, the hæmorrhage was checked, and the patient was comfortable. The case went on until the next morning, when another collapsed state set in. The same bright blood was brought up with that thorough collapse, cold sweat, coldness of the entire

body and drawn up, pinched features. All the China symptoms had returned, so China was given again, and it acted like magic. About one or two o'clock, he again had the nausea. Ipecac. was again given, with immediate relief. In the evening, there again came that intense soreness, and again Hamamelis was given. In the morning, again came the bright blood from the mouth, and down went the patient. He received China this time also. Thus he received these three remedies in alternation. After he had recovered from the hæmorrhages, he received antipsoric treatment. The alternation that was carried out in this case, Dr. Korndœrfer said, was the characteristic "Hahnemannian alternation"; it was the alternation that Hahnemann taught in his *Organon.*

Dr. Korndœrfer also said that he would like to hear from other physicians characteristic symptoms on which remedies are prescribed. He once reported a use of Aconite illustrated by one symptom. He was called to see a case of insanity. The patient had been insane for weeks, and the one central idea of the patient was expressed thus: "If I could only think with my head I would be all right, but I have to do all my thinking with my stomach." There being no other remedy having that symptom but Aconite, that remedy was given, and with the result of curing the case. That symptom is one which Hughes speaks of as being valueless, for it had been experienced by the prover but once, and he could not reproduce it.

Dr. Bushrod W. James referred to the effect of homœopathy on old school physicians, many of whom are carrying with them in their daily rounds little pocket-cases containing parvules, tablets, etc.

Dr. Hugh Pitcairn said that he had recently treated a case which was interesting, because, notwithstanding the most careful study, he was unable to help the patient. A lady in the sixth month of her pregnancy developed the most violent insomnia. Failing to find the indicated remedy, he resorted to dilatation of the os uteri and other makeshifts, but without benefit. One day he discovered the patient eating camphor. The other symptoms besides the insomnia were twitching of the limbs as soon as she lay down, great drowsiness.

Dr. Clarence Bartlett asked if it were not possible for the

symptoms in this case to have resulted from the use of camphor. He had recently read of a case in which large doses of camphor had produced insanity and death.

Dr. Hugh Pitcairn replied that he did not think the camphor the cause of the trouble, for the symptoms appeared before the patient began to eat the drug.

Dr. Bartlett asked if it was not possible for the patient to have deceived Dr. Pitcairn.

Dr. Pitcairn replied that he saw the patient so frequently that he would have detected its odor about her sooner if such had been in the case.

Dr. Korndœrfer asked what remedy cured the case.

Dr. Pitcairn replied that he did not cure it. He brought on labor at the eighth month.

Dr. T. S. Dunning asked if she obtained sleep then.

Dr. Pitcairn replied that she obtained sleep at once.

Dr. Dunning remarked that if the insomnia came from the camphor, relief would not have been obtained by the premature labor.

Dr. Pitcairn thought the same as did Dr. Dunning.

Dr. Cowley suggested Kali bromatum.

Dr. Pitcairn said he had tried that.

Dr. Korndœrfer suggested that in such cases Tarentula cubensis would prove to be a most efficient remedy. He now had a patient who had been suffering for quite a while with uterine symptoms, and who, about eight weeks ago, was suffering from that intense sleeplessness and excitability at night. After reviewing all the symptoms carefully, he was led to believe that the insomnia and excitability were reflected from the uterine condition. He gave Tarentula cubensis[12]. Within four hours after taking the first dose, she was in a comfortable sleep. She slept very comfortably for four hours during the first night. The next night, she slept six hours. Since that time, there have been four or five occasions on which she has had this same nervous trouble, and Tarentula has always brought about an immediate good result.

Dr. Cowley asked if Dr. Pitcairn had given Scutellaria, Opium or Zinc.

Dr. Korndœrfer suggested Magnesium phos. also as a remedy that might have acted in Dr. Pitcairn's case.

Dr. Cowley said that Dr. Van Artsdalen,* in his paper, makes light of herpes zoster. The remedy he himself had used most was Mercurius. He had been led to its use by Dr. Neidhard, of Philadelphia.

REPORT OF THE BUREAU OF OBSTETRICS

Was presented through the Chairman, Dr. J. Nicholas Mitchell. It embraced the following papers:

Puerperal Fever, Allegheny County Society.

a. History and Etiology, W. J. Martin, M. D.

b. Pathology and Symptoms, J. R. Horner, M. D.

c. Diagnosis and Prognosis, W. R. Childs, M. D.

d. General Treatment, John B. McClelland, M. D.

e. Medical Treatment, C. C. Rinehart, M. D.

Case from Practice, by Mary Branson, M. D., Philadelphia.

Three Cases of Extra-Uterine Pregnancy, by J. A. Bullard, M. D., Wilkes-Barre.

Case of Puerperal Septicæmia, by J. Richey Horner, M. D., Allegheny City.

Diagnosis of Pregnancy in the Early Weeks, by Hegar's Sign, by J. N. Mitchell, M. D., Philadelphia.

Puerperal Fever, Clinical Cases, by S. W. S. Dinsmore, M. D., Sharpsburgh.

A Case of Placenta Prævia, by W. J. Martin, M. D., Pittsburgh.

PUERPERAL FEVER

BY THE ALLEGHENY COUNTY SOCIETY.

History and Etiology.

Professor Lusk says that, "in searching through the records of the Health Department of New York city, he found that, from 1868 to 1875, inclusive, a period of eight years, there were 3,343 deaths from diseases complicating pregnancy, from accidents of child bearing, or from diseases of the puerperal state; or, in other words, one in seventy-five of all the deaths occurring during that

*Dr. VanArtsdalen's paper was not received by the Publishing Committee in time for insertion in the Transactions.

period was the result of the performance of what we are in the habit of regarding as a physiological function."

The gentlemen having charge of the preparation of this paper have not selected the subject of puerperal fever with the belief that they would be able to throw any new light upon it, or with the purpose of advancing any new or original ideas as to its nature, treatment or prevention, but from the belief that a disease fraught with such danger to the life of womankind is worthy of our most serious consideration, and from the further fact that many cases of puerperal fever having occurred recently in the practice of physicians of this society, in the western end of the State, we want to have a full and free discussion of the subject in all its bearings.

We propose, after briefly mentioning some of the opinions held by writers of the past on the history and nature of the disease, to summarize, from the writings of the present day, the latest views on the etiology and pathology. The diagnosis and prognosis will be treated of in a clear and terse manner by one of our oldest practitioners and closest observers. The treatment, which we consider the most important part of the paper, we hardly expect to be exhaustive, and we hope that every member present will add his mite to this part of the paper, so that all may be gainers by having had this subject presented.

Very diverse views as to the nature and causes of puerperal fever have been held and taught by medical authors and writers. Some have held that it is nothing more than violent inflammation of the pelvic organs or the peritoneum differing in nowise from what may occur in the non-puerperal state. Others that it is allied to hospital gangrene; and numerous facts have been published which would lead to the belief that the epidemic form of puerperal fever partakes largely of the nature of erysipelas. Thus in Ramsbotham's Process of Parturition, page 426, is the following: "Rigby states that in one epidemic of puerperal fever, at the General Lying-in Hospital, the child of every woman who died of the disease, perished of erysipelas. And I am acquainted with two instances of a like nature that occurred in the practice of one doctor in the same month. Many have remarked the prevalence of erysipelas, as well as malignant typhus when puerperal fever was epidemic. On these occasions, I have known the women who nursed patients

that died of this fever, become the subjects of erysipelas. A striking instance of the analogy between these two disorders, I saw in the Autumn of 1841. Erysipelas was very prevalent, a medical friend of mine had six cases within a few days of each other; while closely watching these patients, he attended a lady in labor in the vicinity of two of them. Puerperal fever speedily showed itself, and the patient died. Her nurse was seized with erysipelas of the hand, and placed herself under the care of another doctor. One day after having made an incision and dressed the hand, this second doctor was called to a case of midwifery; the same kind of fever supervened, and this also terminated very rapidly. I was summoned to the case late at night, and when I arrived, she was dead. A third fatal case attended by the same practitioner I also saw, and others that did well."

Sir J. Y. Simpson believed and taught that there was a pathological connection between puerperal fever and erysipelas. The two diseases, he says, had been repeatedly observed to prevail at the same time in the same town, in the same hospital, or even in the same wards. There were various accurately recorded instances showing that when the fingers of medical men were impregnated with the morbid secretions thrown out in erysipelatous inflammation, the inoculation of these matters into the genital canals of parturient women produced puerperal fever in them in the same way as the inoculation of the secretions from patients who had died of puerperal fever itself. The effused morbid matters in the one disease as in the other, were capable of producing the same effect when introduced into the vagina of a puerperal patient.

There is apparently incontrovertable evidence that puerperal fever has been propagated by medical men carrying on their fingers matter capable of producing it, from bodies which they were dissecting, and inadvertently inoculating that matter into the mucous membrane of the vagina of patients in labor; the perineum is often slightly torn; and the vaginal mucous membrane generally stretched and abraded; and these whole afford a surface easily inoculable.

The immediate cause of puerperal fever is generally considered to be the absorption of putrid matters that lodge in the uterus or vagina. The internal surface of the uterus after delivery has been

very aptly likened to a stump after an amputation. If students and practitioners with their hands containing some portion of morbid matter can thus produce puerperal fever, no doubt, under similar circumstances, surgeons have inoculated into wounds, similar matter producing the similar disease of surgical fever. Dr. Simpson says that since bringing the attention of the profession to the communicability of surgical fever, he had heard various facts in regard to it, all of which more and more convinced him that surgeons, like accoucheurs, are occasionally the unhappy media of inoculating their patients with morbid matter producing surgical fever, as obstetricians by the same means, produce in their patients, puerperal fever. He had no doubt it would take many years fully to convince surgeons of this fact; but still it was his conviction that they would ultimately both believe and act upon it, and that their doing so would be the means of preventing many of the deaths which now occur after operations, particularly in hospital surgical practice. The achievements of modern aseptic and antiseptic surgery have fulfilled this prediction even sooner, perhaps, than Dr. Simpson anticipated.

Dr. Simpson further says that he does not believe that puerperal fever is usually propagated directly from individual to individual, but indirectly through the medium of a third person, and that person generally, the medical attendant or nurse. This belief is founded upon the evidence that the disease is, in most instances, distinctly limited to the practice of one or two practitioners only, out of a large number of physicians practicing in a large community. Many examples were recorded, and many more unrecorded were known to the profession, of the disease being thus limited to the practice of a single physician in a town or city. In these cases, we could not believe it to be owing to any morbific influence present in the air, or emanating from the locality in which the cases occurred. For if so, it would affect indiscriminately the patients of all practitioners; but it has been often seen to haunt the steps of a single practitioner, and a single practitioner only, in a community. One illustration given by Dr. Simpson is very striking. "In 1840 upwards of four hundred women were delivered by different midwives in connection with the Lying-In Hospital of Manchester. These four hundred women were delivered in different parts of the

town at their own homes. Sixteen of them died of puerperal fever; all the others made good recoveries. The production of this could not have arisen from any general epidemic or atmospheric or telluric influence, for the fatal cases occurred in no one particular district, but were scattered through different parts of the town. These four hundred women, or more, were attended, in their confinements, by twelve midwives. Eleven of the midwives had no puerperal fever amongst their patients. The sixteen fatal cases had occurred in the practice of one only of the twelve midwives. There must have been something, then, connected with that one midwife, in which she differed from the others, inasmuch as all her patients took the disease, whilst the patients of all the others escaped from it. And in medical philosophy we cannot fancy that this something consists of aught else than some form of that morbific principle or virus, to which pathologists give the name of contagion. Further, that the disease is really, in such instances, propagated by the physician or the nurse, carrying to the parturient patient a virus capable of producing the disease, is shown by the fact that, when the disease has broken out in the practice of one accoucheur, it will spread to the practice of his obstetrical brethren, provided they put themselves in a condition to carry the contagious virus from the patients of the first practitioner. In 1836 or 1837, Mr. Sidney, of this city (Edinburgh), had a rapid succession of five or six fatal cases of puerperal fever in his practice, at a time when the disease was not known to exist in the practice of any other in this locality." Dr. Simpson, who had then no full and proper belief in the contagious propagation of puerperal fever, attended the dissection of two of Dr. Sidney's patients, and freely handled the diseased parts. The next four cases of midwifery which Dr. Simpson attended, were all affected with puerperal fever, and it was the first time he had seen it in practice. Dr. Patterson, of Leith, examined the ovaries, etc., from these fatal cases, and the next three cases which he attended in that town, were attacked with the disease. It was upon evidence of this kind that British pathologists generally had founded their belief in the communicability of puerperal fever; and it was evidence of this kind which had driven them to adopt those measures of prevention or avoidance, which are so highly necessary in order to

arrest the propagation of this fearful malady. The measures adopted proved, beyond all dispute, the great importance of carefully ridding the fingers from all matters in the least degree likely to prove hurtful if inoculated into the vagina of a puerperal patient. And no doubt such matters were always present in the fingers as long as, despite even of common ablutions, they emitted a disagreeable odor, the presence of that odor being a perfect proof of the presence of morbific matter capable of producing the odor. Dr. Simpson had, for many years, used, for the purpose of ridding the fingers of this morbific matter, a solution of the cyanide of potash. He believed that the imbibition of the effluvia from puerperal fever patients by the clothes of the medical attendant, and the subsequent inhalation of such by the parturient female might be a means of infection. He gives the case of a physician who attended the dissection of a puerperal patient, but did not touch the body or any of the parts. The same evening he attended a lady in labor, and she was attacked with the disease. A medical gentleman, after having lost several cases of puerperal fever, got rid of the disease in his practice by changing his clothes, using chloride of lime, etc., but it again returned to him when he happened to deliver a patient immediately after wearing a pair of gloves which he had used during the time of the puerperal epidemic. And Dr. Simpson, with apparent disgust, remarks that, certainly if there was any piece of our dress more apt to retain the contagion than another, it was this useless and superfluous appendage to our attire. He remarks, further, in speaking of causes, that no doubt sporadic cases of puerperal fever frequently occur traceable to no contagion, or any other cause capable of being averted, some of them owing to morbid actions going on in the constitution of the patient even before delivery.

As predisposing causes, we have given all and any cause which will lead to unhealthy action in general; a depressed, anxious and desponding state of mind, intemperate habits or deficiency of food, and perhaps previous disease existing in the system. During the periods of the epidemic prevalence of this disease, we find that the delicate, the forsaken, the unmarried and the unhappy are the most liable to be attacked, as well as the most liable to be destroyed. Of eight unmarried women who became ill of the disease, only two

survived. It is an old remark of those who have had much experience in lying-in hospitals, that the single women are peculiarly liable to fatal disease after delivery.

With all that has been said as to the contagiousness, infectiousness and communicability of the disease under consideration, it may seem strange that we have to record that "the *non*-contagiousness of puerperal fever is strongly maintained by many able physicians. The most powerful among these is Dr. C. D. Meigs, who writes as follows: "I have practiced midwifery for many years. I have attended some thousands of women in labor, and passed through repeated epidemics of puerperal fever both in town and in hospital. After all this experience, however, I do not, upon careful reflection and self-examination, find the least reason to suppose I have ever conveyed the disease from place to place in any single instance. In the course of my professional life, I have made many microscopical examinations of child-bed fever, but did never suspend my ministry as accoucheur on that account. Still, I certainly was never the medium of its transmission." This statement is indeed remarkable, but it is difficult with any conceivable amount of negative testimony of this kind, to disprove the positive affirmative evidence of many other equally intelligent and no less trustworthy observers.

The following words of Spallanzani are very much to the point here: "It is the custom of certain dabblers in philosophy to deny facts, however particularly described, and though related by persons of the highest authority, merely because their own endeavors (in the same direction) fail of success. But they do not reflect that this is acting in direct opposition to the principles of sound logic by which we are taught that a thousand negative facts cannot destroy a single positive fact." Thus the entire sum and substance of Dr. Meigs's testimony is perfectly expressed in this last phrase; he certainly was not a medium of transmission of such poison, but this amounts to nothing in disproof of others being such mediums.

The statements already given which prove the direct communication of poison sufficient to cause child-bed fever, comprise but a very small portion of those recorded in medical works; these prove what may be termed common communicability, by means of which the poison may be conveyed from a variety of sources

and under a great variety of circumstances. The testimony of Dr. Meigs must be regarded as anomalous, and as furnishing an example of most uncommon incommunicability. But nature is never one sided, we can find in the recorded evidence of medical men some corresponding anomalies on the opposite side, some still more remarkable instances of most uncommon communicability. Thus Dr. Merriman states that he was present at the examination of a case of puerperal fever at 2 P. M. He took care not to touch the body. At nine o'clock the same evening, he attended a woman in labor. She was so nearly delivered that he had scarcely anything to do. The next morning she had rigors and she died in forty-eight hours. Dr. Gooch relates the case of a general practitioner in large midwifery practice who lost so many patients from puerperal fever that he determined to deliver no more for some time, but that his partner should attend in his place. This plan was pursued for one month during which not a case occurred in their practice. The elder then being sufficiently recovered, returned to his practice, but the first patient he attended was attacked by the disease and died. Very similar was the experience of the unfortunate Dr. Rutter, formerly of Philadelphia, as related by Dr. Meigs. This gentleman seemed to be tracked by the cause of the disease, to judge from the numerous attacks of it in his lying-in patients. He was charged with being a carrier of contagion. Worn out with fatigue and wounded in spirit by his cares for the unfortunate victims of an epidemic disease, Dr. Rutter left the city for the purpose of regaining some strength, and to escape from the repetition of such disheartening labors. He spent ten days rusticating at a distance of thirty-five miles from the city, and on his return he caused his head to be close shaved, took a warm bath, dressed throughout in clothes entirely new, leaving behind him even his pencil and his watch, and went out to attend a lady in labor, who had a favorable parturition, yet was next day assailed by a horrible child-bed fever, of which she died. (Guernsey's Obstetrics, pp. 435 and 436.)

We will now, in closing this section of the paper, quote briefly from Lusk's Science and Art of Midwifery. Second edition, 1884. This we take to be our latest and best authority. The teachings of this author, so far as relate to the etiology, &c., of puerperal

fever, we accept and adopt as our own. He says (p. 608): "It has passed beyond the domain of dispute that puerperal fever is an infectious disease, due, as a rule, to the septic inoculation of the wounds which result from the separation of the decidua, and the passage of the child through the genital canal in the act of parturition." "But instances of puerperal inflammations and febrile conditions are sometimes observed, in which the symptoms of blood poisoning are apparently absent or are present only to a subordinate extent, and as a late feature of the disease. (These cases, observe, are called cases of puerperal inflammations, not puerperal fever. But from such a starting point a fatal epidemic of puerperal fever might spring.) Of this class may be mentioned 1. Cases of catarrhal endometritis due to errors of diet and exposure. Indeed I have frequently, in hospital practice, been able to trace severe cases of cellulitis, pelvic peritonitis and general peritonitis, occurring in the winter season, to the patient getting out of bed dripping with perspiration and clad only in a night-dress, and going thus over a cold, uncarpeted floor to the water closet. 2. Cases of puerperal disorders proceeding from emotional causes, the nervous system furnishing the first impulse to the disturbed action. 3. Cases of excessive vulnerability in non-pregnant women; individuals are sometimes found so susceptible that a parametritis follows a simple application of the tincture of iodine to the cervix. 4. Cases of pelvic peritonitis starting from old intraperitoneal adhesions. 5. Cases of peritonitis and retro-peritoneal inflammations secondary to ulcerative processes in the œcum or the descending colon."

An experimental point of practical importance in connection with puerperal septicæmia is the following, viz: If the injection of a septic fluid be made directly into a vessel, toxic effects speedily follow, but are transitory, unless the amount of the fluid be very large, or its virulence exceptional, or the animal very young; whereas very small amounts injected subcutaneously, by developing rapidly spreading phlegmonous inflammation, resembling malignant erysipelas in man, are capable, after a period of incubation, of producing fatal results; or they may, if injected into a closed cavity or underneath a fascia, lead to the development of an inflammation of an ichorous character. In other words, the eliminating

organs suffice under ordinary circumstances to remove from the blood, the same amount of septic fluid which would prove fatal if injected into the tissues. This experience leads us to the conclusion, that in the tissues, septic poison possesses the capacity of self-multiplication, and that in the local inflammation set up, a reservoir is formed from which poison is continuously poured into the circulation. This capacity for self-multiplication which septic fluids possess, is found to be coincident with the presence of certain organic bodies, termed variously micrococci, microspores, less specifically bacteria. Carefully made experiments serve to show that if a septic fluid be deprived of these organic bodies by boiling or filtration, while it continues capable of producing inflammation, the inflammation is usually of diminished intensity and remains local in character, whereas the microspores retained upon the filter, possess all the virulence of the original fluid. As to the exact manner in which these minute bodies exercise their pernicious influence, whether they operate mechanically, or whether they produce a virus in the process of nutritive activity, or whether as is probable, both suppositions are correct, must be left for subsequent investigation. But we can see now that the question as to the extent to which erysipelas and puerperal fever are cognate diseases is in a fair way to be solved. Thus we find in surgical fever, in puerperal fever, in diphtheria, and in erysipelas, the presence of a common element which links them together, and which establishes the relationship which has long been recognized as existing between these various processes. Whether the bacteria are identical in the different infectious diseases in which they have been recognized is another question, but whether identical or not, they all possess the common property of penetrating the tissues under favorable circumstances, of multiplying and of producing by their migrations, local inflammations and general infection.

In the *American Journal of Obstetrics and Diseases of Women and Children*, Dr. E. Nœggerath describes, with chromo-lithographic plates, a certain form of puerperal fever microbe, which he obtained from blood clots, discharged from the uterus of a woman with a protracted child-bed fever. He denominates the parasite as belonging to the saprophytes, and says that we must call the fever described, sapræmia, and not septicæmia. That this

distinction is now fully established as existing in fevers occurring during the puerperal state. Sapræmia, is simple putrid infection, not a poison from an organism which goes on developing in the blood. He says that it is almost always the case that puerperal fevers are produced by one or another form of coccus, most often the streptococcus.

At Bellevue and at Maternity Hospitals, says Lusk, I have had frequent occasions to witness febrile outbreaks among the patients in the lying-in service, which were instantly arrested by closing the ward and transferring the inmates to a wholesome locality. These outbreaks are not due to the transfer of the poison from patient to patient, or to overcrowding, but to what has been termed nosocomial malaria. When the disturbance produced by this nosocomial malaria is not arrested by change of locality, and the golden moment is allowed to slip by, the secretions of the patient affected become inoculable, and the epidemic spreads rapidly, and assumes continuously a more and more severe type. Apart from the nosocomial malaria of hospitals, there is reason, as the examination of mortality statistics will show, to believe in the influence at times, of certain general widespread atmospheric states which affect the entire community.

Though the argument is very strong in favor of regarding the genitalia of puerperal women as the exclusive point of entry of infectious materials into the system, it seems impossible, at the present time, to make all facts coincide with such a theory. I have the records of a number of cases occurring during an epidemic of puerperal fever, in which patients were either attacked with fever previous to parturition, or in whose cases, the unusual length of labor, the frequency of post-partum hæmorrhage, and the imperfect contraction of the uterus immediately after confinement, were signs of some abnormal influence exercised upon the economy at an early period of labor, previous to the existence of traumatism. That deleterious materials may find other channels for entering the system than a wound surface, is evidenced by the cachectic condition not unfrequently produced in physicians by too assiduous attendance in dissecting rooms and places in which post-mortem examinations are conducted. It does not yet seem quite time to give up the idea that, under exceptional circumstances, the respi-

ratory, and probably the digestive, tracts may allow the passage of materials of a septic character.

Another and frequent source of puerperal fever is by direct inoculation. Any material of a septic character, introduced into the genital passages of a woman during or after confinement, may produce a general infection of the system. But the main point is, that it is possible to trace epidemics of puerperal fever directly to carrying puerperal poison from patient to patient through the medium of attendants. In such cases, changes in wards and the most rigid sanitary precautions avail but little, as long as the affected person is continued in charge; and unless this fact is fully recognized, all the cleverest devices in hospital construction will fail to prevent the occurrence of disasters. In epidemics, this source of danger is especially to be guarded against, as septic poison is increased in intensity by successive inoculations. When a number of animals are poisoned, the one from the other, while from ten to fifteen drops of putrid blood were required to produce death in the first animal, one ten-trillionth part of a drop was sufficient in the twenty-fifth animal of the series, and in puerperal fever epidemics, a similar augmentation in the deadliness of the poisons generated by patients, is observed. The nurses in hospitals and in private practice are usually the carriers of the contagion.

With the view of ascertaining how far experience corresponds with the theory that puerperal fever owes its origin to poisonous materials obtained from dissecting rooms, and introduced into the genital canals by the hands of physicians attending cases of labor, Dr. Lusk made personal application to a number of gentlemen who have engaged in midwifery practice while performing the functions of demonstrators of anatomy in our medical schools. The report of all is to the effect that they attended midwifery cases while at the same time attending to their duties in the dissecting room, and that their midwifery cases all did well. Of course there is no question but that it is a perilous experiment to pass from the dissecting room to a patient in labor without employing rigorous measures to disinfect the hands and all parts of the person brought into contact with the dead body. But it is well to call attention to the fact that puerperal fever is not due to any single simple cause, nor can it be effectively guarded against by a single precaution; and again, that

cadaveric poison does not of necessity exist in every cadaver examined.

W. J. MARTIN, M. D.

PATHOLOGY AND SYMPTOMS.

PATHOLOGY.—During parturition the soft parts are usually subject to laceration, more or less extensive, according to the relative size of the fœtal head and the canal. These lacerations take place, generally, at the os uteri or the vulva. In the majority of cases, resolution takes place at once, but sometimes the tissues ulcerate, giving rise to the "puerperal ulcer." Frequently this is located on the ruptured perinæum, though it is sometimes found on the vaginal surface after the perinæum has entirely healed. The surface of the ulcer is covered with a brownish-green deposit, the surrounding parts are slightly inflammed, and the labia are œdematous. Under favorable circumstances, granulation and resolution take place early, and no further consequences are noted. This is the simplest form.

At times, the surface of the ulcer presents a decidedly diphtheritic appearance, which extends to the vaginal mucous membrane, or even down the thighs. There is intense œdema and erysipelatous redness of the parts.

By extension of the inflammatory process, the uterine mucous membrane is involved, and may present a severe catarrhal inflammation—catarrhal endometritis. Ulceration and mortification may occur, and the whole mucous surface may be covered with diphtheritic patches. These are yellowish-brown in color, and from them masses of detritus may be scraped.

Where the whole surface of the endometrium is involved, there will be found either brownish particles or a smeary, chocolate-colored mass, involving either the superficial or the deep mucous layers, according to the amount of serous transudation. The uterus is found to be soft and pulpy, and its entire mass œdematous. In very bad cases, pus originating in the puerperal ulcer, fills up the uterine lymphatics, and at times, though very rarely, purulent salpingitis occurs.

The endometrium being inflamed, the uterine parenchyma be-

comes involved. We find œdema, imperfect contraction and soft and pulpy tissues. If the inflammation extends deeply, it results in *putrescentia uteri* and perforation into the abdominal cavity.

The inflammation may extend from the connective tissue about the broad ligament to the iliac fossa. Thence it spreads in different directions, though not usually, affecting the bladder. In mild cases, the œdema quickly disappears. If there is but little accumulation of cell elements, no trace of the disorder is left; otherwise after fatty degeneration and absorption of the liquid portion, a hard tumor, composed of fine granular detritus, is formed, and this, under favorable circumstances, finally becomes absorbed. In very rare cases suppuration occurs. In many cases of parametritis, we find thrombosis of the lymphatics without the inflamed area. This is favorable, as it prevents extension of the morbid process. Very rarely the ovaries are implicated.

Pelvic peritonitis is caused either by severe attacks of catarrhal endometritis, or from stretching and irritation occasioned by an associated parametritis. There is a catarrhal exudation on the surface of the membrane of Douglas' cul-de-sac, the broad ligaments and the ovaries. This may be but slight or so extensive as to result in formation of false membranes, by which adhesion of the pelvic organs occurs, and in consequence of this, more or less serious derangement of these various organs.

The general peritoneal membrane usually shows signs of inflammation due to extension of the morbid process from the surrounding tissues. In mild cases, we find the peritoneum, and especially that part of it which invests the intestines, finely injected. Serous exudation occurs, and consequent adhesion of the abdominal organs. Or there may be a deposit of coagulable fibrine over the liver, intestines and uterus; the intestines becoming much distended, and the diaphragm displaced upward.

In the most serious and aggravated cases, the exudation, instead of being serous or fibrinous, is purulent or of a brownish color and very putrid. The intestines speedily become black and gangrenous. When the poison has been directly conveyed by means of the lymphatics to the abdominal cavity, there are but few inflammatory symptoms. The cavity is filled with an offensive, thin, greenish fluid, the fibres of the intestinal and abdominal muscles

become lax, and the subsequent formation of flatus produces abdominal distension. The peritoneum is covered with gangrenous patches, and very quickly becomes decomposed.

At times thrombi are formed. They are the result of an inflammation of the mucous coats of the uterine and pelvic veins. Generally, those veins are affected which pass through portions of the uterus or surrounding tissues, which are infiltrated with purulent material. The endothelium undergoes proliferation and thickening, and a blood clot is thus formed. This thrombus of itself is harmless. It is only when inflammation affects it, that it becomes a serious factor. In this case, degeneration and disintegration rapidly occur, and the emboli thus formed are carried into the general circulation. Wherever they lodge, inflammation is set up, and abscesses are the result. To this source may be traced the pulmonary and hepatic abscesses so often the result of puerperal fever.

Puerperal septicæmia, a condition arising from the absorption into the general system of poisonous matter or organic material, which has become decomposed. It is similar to surgical septicæmia, and the local inflammations and pathological conditions above described are among its results. Any or all of the organs may be affected with inflammation during its course, and a constantly elevated temperature, almost the only symptom, be the result. This condition has been explained as follows: The blood, becoming loaded with septic matter, is capable of causing imflammation wherever it circulates, and as long as this matter continues to be absorbed, just so long will be kept up the local inflammations and rise of temperature. In some cases, it has been observed that the serous membranes are most prominently affected; in others, the mucous membranes, and in still others, the lymphatic system. Abscesses may form in any tissue or organ, as a result of this pyæmic process.

At times, the infection is so intense and the poison so active and abundant, that death occurs before any pathological changes have taken place. Autopsy shows only that the blood is dark and non-coagulable, and the various tissues are ecchymosed.

Symptoms.—The first symptoms of puerperal fever generally appear on the second or third day, rarely later than the fifth day. The first

noticed is slight chilliness affecting only the back; or there may be a well defined rigor. But the symptom which, if present on the second or third day, should incite careful attention and watchful care is *headache*—severe and persistent. Beyond this, the symptoms vary greatly according to the organs or tissues involved, though there is always high temperature, enlarged spleen, arrested involution and sensitiveness of the uterus.

In order to have a clear understanding of this disease, we may arrange the symptoms under four distinct heads, viz.:

(*a.*) Parametritis and pelvic cellulitis.

(*b.*) Perimetritis and peritonitis.

(*c.*) Metritis and uterine phlebitis; and

(*d.*) Pure septicæmia.

It is not easy to distinguish between parametritis and perimetritis, because the pain associated with the former is generally of such a character as to indicate implication of the peritoneum. In fact, it must be very rare for one form to occur independently of the other. Accordingly, we have included under the head of parametritis all those cases which, from the *moderate* pain experienced, are more likely to belong there; while those cases which are attended with intense suffering with further evidence of peritoneal inflammation *which is limited*, we included under the head of perimetritis and pelvic peritonitis.

Parametritis, pelvic cellulitis. The onset of this form may or may not be preceded by a rigor. The temperature runs up to perhaps 105° or 106° on the first or second day. It does not remain here however, but remits or may intermit, and occasionally the temperature is at no time much above normal. The pulse usually corresponds with the temperature. When, however, the temperature remains very low and the pulse continues rapid, a very grave and serious symptom is presented.

Pain and sensitiveness are always present either on one side of the uterus or on the other.

An important diagnostic symptom, and one not easily distinguished, is the presence of swellings formed from infiltration of the cellular tissue most often between the folds of the broad ligament. This is the pathognomonic symptom of the disease and is discovered by the conjoint touch. Sometimes the tumor lies closely to the

side of the uterus, appearing to be only an unusual thickness of uterine walls, and in another case there may be diffused exudation in the region of the internal os uteri, extending backwards and thus eluding the touch. Most often, the tumors are limited to one side of the uterus but they may be on both, though differing in size, or they may be so low as to encroach on the vagina. At times, though rarely, the tumors occupy one iliac fossa or the other, and are to be distinguished only by abdominal palpation.

After a time, inspissation of the tumors takes place and in a few months, they are completely absorbed. Resorption is accompanied with hectic fever, but in favorable cases, the temperature soon becomes normal. Rarely, suppuration takes place and the abscess soon perforates the rectum, vagina, uterus, bladder, abdominal cavity or external abdominal walls.

Resorption does not always take place, however, owing to irritation, and then the tumor contracts, hardens, and becomes permanently fixed.

Pelvic peritonitis or perimetritis usually sets in on the second or third day, chilliness or rigors preceding the febrile condition. This is accompanied with pain and tenderness on *both* sides of the uterus. These symptoms yield in a few days to proper treatment or the inflammation may extend and *general peritonitis* follow. More often, however, this form of puerperal fever results from a pyæmic condition, and in this case, the pains resemble those of pelvic peritonitis but are more slowly developed. The pain is intensified and diffused over the abdomen ; tympanitis is present and may be so great as to cause dyspnœa. The abdomen becomes excessively sensitive, the patient throwing off all clothing and lying prone upon the back with the knees drawn up so as to relieve tension on the abdominal parieties. The disease progressing, effusion occurs.

The lochia often continue undisturbed, or may become fœtid and diminished or altogether suppressed.

The secretion of milk is prevented if the attack has come on before the flow is established; if afterward, the secretion is suspended and the breasts become flaccid.

As the temperature varies, it is not to be depended on. The pulse, however, is more constant, rising rapidly to 120, 130, or

160 beats per minute. In fatal cases, it becomes still more rapid, while the temperature finally descends.

The tongue is generally white in the centre, and red about the edges ; sometimes, it is dry and brown in the centre, with yellowish or white fur at the edges. Vomiting of bilious, green, brown or black fluids occurs ; and there may also be diarrhœa. The urine is turbid, or high colored and scanty.

In fatal cases the countenance assumes an expression indicative of great distress, the forehead is cold and moist, the pupil dilated, the eyes lustreless and unearthly, and the extremities and finally the body cold ; and under this collapse, the patient sinks in a few hours.

Such is a description of a fatal case. When, however, recovery takes place, the diffused exudation becomes encapsuled, and the uterus agglutinated to the surrounding structures.

Metritis.—In this form, the attack may begin before delivery or almost immediately after, and it is then exceedingly malignant and runs rapidly to a fatal termination. Uusually, the disease begins on the second or third day with chilliness or distinct and well defined rigors. The pulse is very rapid, full and soft. Distention with pain and sensitiveness of the abdomen may or may not be present. There is generally epigastric pain and tenderness with nausea and vomiting. Profuse sweating is a constant symptom, the sweat having a sweetish, pus-like odor. Thirst is very great, the tongue is flabby, broad and shiny, and covered with a yellowish coating. The countenance is pale and expressionless, or where the pain is acute, is anxious and covered with perspiration. Dark spots appear on the wrists and other parts of the body. The lochia are usually entirely suppressed but may continue undiminished, though after a time, they become fœtid.

As the disease progresses, diarrhœa may supervene ; the patient becomes nervous and anxious, the pulse is soft and rapid, the respiration quick, hurried and panting. This latter symptom, in connection with excessive distension of the bowels, is a very grave indication. Lactation is almost always checked, and may be entirely suppressed.

Uterine phlebitis is to be recognized long before the objective symptoms of external suppuration are presented. Dr. Meig's says:

"Hysterical or hysteroidal, and even maniacal symptoms, invariably mark purulent infection of the blood, and these affections in women recently delivered and assailed with fever, are really the exhibitions of that curious influence which pus in the blood or pyæmia, exerts on the nervous system. As the disease advances, the more palpable phenomena attendant upon pus formation in the veins are developed by the deposit of purulent matter in various parts of the body, and especially in the vicinity of the large joints. In such cases, we find swellings in the neighborhood of the articulations, erysipelatous blushes and large suppurations in the vicinity of the joints, or patches of slough and gangrene form at the sides of the erysipelatous blushes."

We may have pulmonary abscesses, the temperature maintaining a higher and more constant level, and the pulse becoming small and rapid. The patient becomes soporous and slightly delirious, and the skin and tongue are hot and dry. The percentage of recoveries is small, though usually the fatal termination is postponed until the second or third week.

Pure septicæmia.—In cases of intense septic infection, death may occur within thirty-six hours after the inception of the disease. The attack comes on very suddenly, the temperature rises rapidly, the pulse, at first full and vibrating, becomes small, hard and incompressible; the head aches violently, the skin is hot, the tongue white and moist. Soon the patient becomes delirious and comatose, and death follows.

In the commencement of this form of child-bed fever, the nervous system of organic life appears to be suddenly and seriously affected, as is shown by the general loss of vascular tone and of nervous power, by the disturbance of the vital functions, by the rapid exhaustion and by the sudden death. In these cases, the vital forces are, probably, overwhelmed by the intensity of the attack, but we have other cases of what might be termed pure septicæmia, following a more protracted course and yet evincing no decided lesions.

J. Richey Horner, M. D.

DIAGNOSIS AND PROGNOSIS.

Puerperal fever is not difficult to distinguish from other diseases. Its occurrence soon after delivery, the pronounced character and alarming rapidity of its progress is found in no other ailment of the female sex. The acceleration of pulse, rigors more or less distinct, anxiety of mind (in some cases a sense of impending danger), will be the first symptoms of this dreaded malady. The pulse rising suddenly above one hundred, violent headache, any unusual symptoms, pains which differ in character from after pains, which, as a rule, gradually abate until, at the end of the third day, they have disappeared. The pain in this condition is aggravated by pressure and motion, and becomes more severe. These symptoms constantly increase as the disease progresses.

The secretion of milk may not occur, or, if it has shown itself, may be suppressed. The lochial discharge may cease or become thin, profuse and foul. The tongue is red, and thirst is ever present. The different forms of the fever have different manifestations. The puerperal metritis, puerperal peritonitis, uterine phlebetis, and that form in which the nervous system seems to have received a severe shock, and death ensues in a few hours.

The cases where, from putrescence of retained portions of placental tissue, we will have pyæmic complications to contend with, Simpson says, "death occurs after injuries or surgical operation from surgical fever, a disease consisting of a composition of co-existing fever, acute fever and acute internal inflammation, just as puerperal patients die of puerperal fever, a similar compound disease, consisting exactly like surgical fever, of co-existing acute fever, and acute fever and acute internal fever."

The prognosis of this malady is always unfavorable, but under the beneficent treatment of homœopathy, we have many notable cases of recovery. Wm. R. Childs, M. D.

GENERAL TREATMENT.

This important feature in the management of the most dreaded of all diseases unfortunately does not comprise much. Preventive measures, however, should be inaugurated to avert, if possible, this fatal calamity to the parturient woman.

The bed and bedclothing should be scrupulously clean, the latter well aired before the beginning of labor, and all soiled and bloody clothing, both of the patient and of the bed, should be immediately removed from the room after its termination; nor should the accoucheur be unmindful of himself. No examination should be made without first washing the hands and arms, thoroughly scrubbing and cleaning the nails, and rinsing in carbolized water. Some physicians change their whole attire before attending a case of labor. The bed-chamber should be light and cheerful, and an abundance of fresh air admitted. The lochia should be closely watched for any signs of fœtor, and at each visit pressure made over the uterine region, for the purpose of detecting the first evidences of undue tenderness. The genitalia should be frequently bathed, and vaginal douches of two per cent. carbolized water employed three or four times in the twenty-four hours. Napkins, composed of navy oakum, covered with thin open-meshed muslin, should be applied to the vulva to receive the lochia, the tow acting alike as a disinfectant, as well as a preventive to the entrance within the vulva of septic germs. The pulse and temperature should be noted at each visit.

If, notwithstanding all the precautions possible, we are confronted with a case of puerperal fever, active measures must be begun at once. If the general peritoneum be invaded, then hot fomentations, frequently repeated, will be of great benefit, or hot turpentine stupes, 1 to 5 of water, will be found to be effective. After the subsidence of the acute symptoms, there usually remains a localized soreness, for which many good practitioners of our own school use cataplasms of mustard or a fly blister, or some even apply leeches, though how it is that that proceedure can be of any service, when we consider a pump behind them forcing the blood to the spot, in larger volume than their microscopic mouths can possibly take away, has not yet been explained.

Venesection in all forms of puerperal fever was largely practiced a few years ago; even now it is not obsolete with some physicians. Twenty to twenty-five ounces was the quantity removed at one bleeding. It may be of interest to the present generation to cite the methods as practiced thirty years ago.

I will quote Professor Meigs: "The patient was seized with the

fever when she was immoderately bled to the amount of twenty-five ounces. The case continued under treatment nine days, during which time there were extracted from the arm forty-seven ounces of blood, fourteen dozen leeches were applied to the abdomen, four hundred and sixty grains of calomel and twenty-three grains of opium were administered, together with five warm baths, constant stupes, and occasional draughts of castor oil and turpentine." Notwithstanding all these vigorous measures, the Professor adds, the patient succumbed.

Even at the present day enormous quantities of opium are prescribed, simply for the peritoneal pain. Professor Lusk stated that a patient of Professor Alonzo Clark received the equivalent of 934 grains of opium in four days; a patient of Dr. Howard Pinkney was hypodermically injected with 13,969 drops of Magendies' solution in eleven days, and that a patient of his own was given the equivalent of 1,700 grains of opium in seven days. His own patient recovered, but he does not say what became of the other two.

Cold packs are also of great service in acute peritonitis. The patient is allowed to remain in them ten minutes at a time, then wrapped in a sheet without drying, and comfortably covered.

Were we to have the uterus or the pelvic cellular tissue attacked, hot vaginal douches of 80 to 90 degrees, carbolated, should be employed for five minutes every two hours; or instead of carbolic acid, the permanganate of potash, or iodine might be added to the water. The latter is spoken of highly as an antiseptic.

When the lochial discharge is very offensive, and its appearance shows placental debris, then intra-uterine douches are necessary. But they must be used with great caution. C. Braun says: "We must protest against injections into the uterine cavity. Such meddlesomeness is more likely to do harm than good." Accidents, such as convulsions, shock and carbolic acid poisoning, from their use have been reported.

This caution, says Professor Lusk, is not intended to discourage the employment of intra-uterine antisepsis, in cases where it is strictly indicated. Thus he says, and truly, it would be folly in a fever due to the decomposition of placental debris, of shreds of decidua, of strips of membrane, or of retained coagula, or in diph-

theritis of the mucous membrane, to treat the general symptoms, and neglect the local cause of difficulty. Before beginning the intra-uterine douche, the vagina should first be well washed out with a two per cent. solution of carbolic acid; the continuous stream is much more preferable for the intra-uterine, or the vaginal douche either, than the interrupted. Its advantages are so apparent as not to require any explanation. In the treatment of pelvic exudations, the hot vaginal douche, warm baths and the application of flannels, wrung out in hot water, to the abdomen, help to relieve pain, and may even contribute to the absorption of the exudate. Where, however, it has gone on to the formation of pus, as is indicated by the condition of the patient, the seat of the deposit must be discovered, and, if possible, evacuated. The local treatment is then similar to that of any abscess.

During the continuance of the acute symptoms of any of the varieties of puerperal fever, the diet will have to be carefully ordered. The patient should be given liquid nutritious food and cool water as much as she desires. After the acute symptoms have subsided, and we have evidence of peritoneal effusions, pelvic exudation, or the presence of pus, she will have to be well supported by rich, easily digested foods, milk-punch, egg-nogg, etc., etc. Puerperal fever seems to be now generally accepted by the profession as a form of septicæmia; the administration of alcohol in some form in large quantities daily is recommended as an antidote to the evil effects of the poison upon the heart, and with good effect.

J. B. McClelland, M. D.

PUERPERAL FEVER—TREATMENT.

Puerperal fever is a disease requiring immediate attention and the most careful and pains-taking prescribing, and even with the utmost care and most skillful attendance, the mortality will be large.

In presenting the remedies I have thought it best to give them in the order of their usefulness, rather than in alphabetical order.

Probably the most useful remedy in the early stages is—

Bellad.—Violent pains coming and going suddenly; pains in the abdomen as if clasped with claws; abdomen distended and sensi-

tive to the slightest touch; pressure as though all the parts would issue through the vulva with constant ineffectual desire for stool (Nux vom. has the ineffectual desire for stool but does not have the sensation as though everything would protrude). Lochial discharge suppressed, or vitiated and fœtid, congestion of head with delirium, throbbing of the carotids; face red; light and noise are intolerable; even a jar of the bed or persons walking across the floor causes suffering; drowsiness with inability to sleep, or dosings with sudden startings.

Veratrum viride divides the honors with *Bellad.* in the iniatory stages. It is useful in puerperal metritis or peritonitis. When the pulse is quick and weak, headache, violent throbbing, particularly frontal; intense fever, restlessness, excessive pain, abdomen distended, skin cold and clammy.

Similar to Veratrum viride is *Aconite*, which also has high fever, restlessness and painful and sensitive abdomen, but the skin is dry and burning, violent thirst for cold drinks, red and hot face, breath short, sighing and difficult respiration; periodical and cutting pains through the whole abdomen.

Aconite is seldom useful save in the early stages and in the sthenic forms of fever.

Nux vomica is a remedy of great value, and is indicated by pain in the neck of the uterus as if bruised; frequent desire to urinate, with pain, scalding and burning. Frequent ineffectual desire to defecate; suppression or too profuse discharge of offensive lochia, with violent pains in the small of the back which are made much worse by attempting to turn in bed. Nausea with a desire to vomit or actual vomiting; pain in the forehead above the eyes, with fainting spells; dimness of vision, vertigo and ringing in the ears. Despondent, sleepless, or dreams frightful dreams.

The similarity between Nux vomica and *Cantharis* is very manifest in some of the symptoms. Both have frequent urination with burning and scalding and passage of small quantities of urine, but in Nux vomica, the difficulty is spasmodic, largely due to spasmodic action of the neck of the bladder, and vesical irritability; while with Cantharis it is due to extension of the inflammation to the bladder. With Cantharis, there is also burning in the uterine

region (Tereb.). The vesical symptoms, however, are of the greatest importance in the selection of this remedy.

Bryonia.—Distended abdomen, sensitive to contact or motion; headache as though the head would split open; sitting up in bed causes nausea and fainting; violent fever wlth burning heat of the whole abdomen; lids and mouth dry and parched; great thirst with desire for cold drinks in large quantities; constipation, stools hard and dry as if burnt; irritable, vehement or apprehensive for the future.

Rhus tox.—Offensive lochia, lasting too long or often returning (Kreas.). Milk suppressed; great restlessness; cannot lie still, changes position constantly, which affords a temporary relief; slow fever; dry tongue; extremities powerless, can scarcely draw them up; pain worse at night and especially after midnight.

Arsenicum also has great restlessness but the prostration is more marked, there are burning, throbbing, lancinating pains, and accompanying the restlessness there is great anguish and fear of death. Thirst for frequent sips of cold water which aggravates her symptoms. Great prostration, sunken countenance, sallow or livid complexion, nausea, vomiting, dizziness, headache, delirium. Small, feeble pulse; desire to be kept warm.

Baptisia has also extreme restlessness, but motion does not relieve. Septicæmia with typhoid symptoms; fœtid lochia, great prostration; abdomen distended, fullness, flatulent rumbling. Feels as though vomiting would relieve. Sharp, shooting pains in the bowels; urine scanty, dark red; breathing oppressed on lying down, but without constriction of the chest. Indescribable sick feeling all over. Headache as though the head would fly to pieces; thinks she could go to sleep if she could get the pieces together.

Secale corn.—Tendency to putrescence; discharge of sanious blood, with tingling in the legs and great prostration; urine suppressed; offensive diarrhœa; voice hollow, feeble and inaudible with difficult breathing. Burning fever interrupted by shaking chills; cold limbs and cold sweat over the whole body. When the putrescent material is absorbed into the circulation, there is tingling and coldness of the extremities, and a condition of mind in which the patient has a mania for light, laughs, claps her hands,

talks vociferously, tries to jump out of bed. The symptoms here would seem to strongly indicate Stramonium, but Stramonium would certainly fail. This condition is septicæmic intoxication, in which Secale is the remedy, and is not a cerebral hyperæmia indicating Stramonium.

Veratrum album has many symptoms similar to Secale corn. It has the great prostration, suppressed urine, feeble, hollow and inaudible voice, offensive diarrhœa, cold limbs, and cold sweat over the whole body; but in Verat., the prostration is due to rapid sinking of the vital forces, while that of Secale is generally due to a gangrenous condition. Secale is a picture of septicæmia, while Veratrum covers a condition of shock and consequent torpor of the vegetative system, with filtration of the liquid portion of the blood through the tissues, producing copious diarrhœa and vomiting and the cold, clammy sweat for which this remedy is so efficient.

Veratrum lacks the restlessness, anxiety and anguish of Arsenic; it is not characterized by any considerable pain. Its prostration differs from that of Arsenic in that it is not greater than we would expect from the copious vomitings and diarrhœa, while that of Arsenic is out of proportion to the losses.

Kreasote.—Stitches in the vagina proceeding from the abdomen, causing starting at every pain; very offensive and excoriating lochia, which almost ceases and then freshens up again (Rhus). Urine fœtid, brown; stools putrid, abdomen tense and distended; labor like pains in the abdomen extending to the small of the back; flushes of heat in the face; painful sensation of coldness in the abdomen.

Terebinth.—Metritis and puerperal peritonitis; lochia checked; terrible burning in the uterus (Canth.). Abdomen tympanitic and sore to the touch; burning urination. Headache; brown, dry tongue; thirst; nausea and vomiting; pulse small and frequent, with general debility.

Lachesis.—Lochia fœtid; urine suppressed; abdomen tympanitic and sensitive to the least pressure; cannot bear even the bedclothes to touch the uterine region. Uterine pains relieved by a flow of blood, but return soon afterwards. Always worse after sleep.

Hyoscyamus.—Hyos. is, in many of its symptoms, similar to

Bellad., but has less congestion and fever; the type is more typhoid; the mental symptoms are peculiar and characteristic. The patient is bewildered by hallucinations that are only half real. She is quarrelsome, loquacious, has a tendency, in talk and action, to obscenity. She desires to be naked, and will not keep the clothes on the bed. The extremities jerk, the face and eyelids twitch; delirium. It is especially useful when the inflammation has developed from emotional disturbances.

Stramonium may be said to stand between Bell. and Hyos., having less fever than Bell., and more than Hyos. The face is turgid with blood; she awakens with a shrinking look as though afraid of the first object she sees; she desires light and company; is disposed to talk continually; imagines all sorts of absurd things; the hallucinations take complete possession, differing in this respect from Hyos., in which the hallucinations are only partial and bewilder the patient. The loquacity is not so marked, and there is no quarrelsomeness, but rather good nature.

Chamomilla.—The inflammation has been developed after a fit of anger. The mammæ are flaccid and empty; whitish diarrhœa; lochia scanty; abdomen distended and sensitive to contact; heat and great thirst; she is ill-humored and can scarcely treat her attendants with civility. There is the quarrelsomeness of Hyos., but no delirium. The patient has her full senses but is unbearably cross.

Gelsemium.—Headache, the pain commences in the back of the head and spreads all over it; head feels enlarged; dizziness with blurred vision; the head feels sore both internally and externally; sensation of a band around the head. Sleeplessness or restless sleep with unpleasant dreams. Chilliness, languid, aching in the back and limbs; chills running up the back or begin in the hands; hands and feet cold, head and face hot. Fever heat with drowsiness; languid, wants to lie still, no thirst. Heavy, besotted expression of the face (Bapt.). Face flushed and hot to the touch. Tongue feels so thick she can hardly speak. In many of its symptoms, Gelsem. resembles Bell., but it has not the febrile violence or suddenness of aggravation which characterizes Bell.; is more heavy and stupid. The face has the heavy, besotted look of the Bapt. patient, but the headache is different and it also lacks the restlessness of Baptisia.

C. C. Rinehart, M. D.

CASES FROM PRACTICE.

BY MARY BRANSON, M. D., PHILADELPHIA.

When asked by the Chairman of this Bureau to write for the coming State Society Meeting, he said: "If you *can*, write something of statistical value, in the way of clinical cases, illustrating the value of the homœopathic remedy."

Light esteem seems to be placed upon homœopathy in obstetrics by many people, more particularly by the laity. Parturition is regarded either as a natural process, with little care needed other than that given by the midwife or nurse, or, if abnormal, a surgeon is accounted more suitable to complete the labor, little reliance being placed upon remedies.

Only a few weeks ago, being called from the city, I gave an obstetric case into the care of a substitute, but the lady's husband did not accept the change, remarking that, as his wife could not have the physician of her choice, he would make his own selection, having at all events a preference for a surgeon, at such a time. Again, in choosing her accoucheur, the prospective patient will be advised to be certain to engage a physician who is especially good in labor cases, without reference to the school, as a good allopathist is better than a poor homœopath, etc. In truth, one can but feel the force of the comparison, though an unfair one. Let us see to it that this cannot be said, for in addition to skill in attending a parturient patient, if the homœopathic remedy is discreetly administered, great good is accomplished, and the school and the medicine *will* make a difference in the choice.

Mrs. C., although strictly homœopathic in her family, held always to the one old school physician in each of her nine confinements, saying she did not like to make any change, Dr. L. was so kind to her, and the "regulation" dose of oil that he always administered on the fifth day did her no harm. Her labors were tedious and severe, but nothing could prevail upon her to change her school at this time, "for what could medicine do in a natural process?"

Mrs. M. had four children under the old school; she was ailing during her entire pregnancy, discouraged and exhausted. When

pregnant six weeks with her fifth child, she placed herself under the care of a homœopathic physician. Through remedies carefully selected, her indigestion ceased, she became perfectly well, and her labor was natural, with excellent recovery. The sixth pregnancy, also under homœopathic treatment, was attended with equally good results. This does not imply continued dosing, another slander our school has to bear, but only the careful prescribing for symptoms as need may occur. "Homœopaths are always dosing, the medicines are easy to take, and do no harm, and that is the reason I am disgusted with it," was said to me the other day. This objection needs to be guarded against, but, on investigation, it is a question whether there *is* more dosing in the new than in the old school. There, it is paregoric, laudanum, nitre, mustard, citrate of magnesia, and quinine (taken almost as a food); or, worse than all these, the deliciously tasting tonics, mostly alcohol, taken for every little ache or pain, or feeling of lassitude. Then, too, the remark that the "homœopathic remedy will do no harm, even if it does no good," is a false one. It does not destroy life directly, but it disturbs the system, renders it torpid in responding to correct remedies, and gradually undermines the health.

In one year, there occurred in an allopathic hospital five deaths from puerperal fever, and nearly every parturient patient attended there during that time, had high pulse, pain, tympany and many unsatisfactory symptoms. The disease took various forms of blood poisoning: peritonitis, metritis, septicæmia, abscess, phlegmasia alba dolens, phlebitis, typhoid, malarial, diphtheritic, etc. Scrupulous care in nursing and disinfection was taken in every case. Complete quarantine was enforced, prophylaxis, antisepsis in every point was followed. Antiseptic vaginal injections were depended upon from the day of confinement. Throughout the entire period it was accounted an actively contagious or infectious malady. The physicians attending a case of fever did not see the other patients, and the physician on duty in the obstetric wards did not enter the fever district. Quinine was the main dependance, fifteen, twenty, and up to forty grains in the twenty-four hours, but with generally unsatisfactory results. When improvement occurred, it could not be traced to the quinine, and it was during my experience in this epidemic that I looked longingly to

the other school for something better, and found it! The satisfactory results in the homœopathic school that are manifest to the writer, especially in the post-partem period, would suggest the idea whether or not the dose of Arnica, invariably administered to the exhausted patient, after a protracted or unnatural labor, has aught to do with bringing about this happy condition.

The following quotation from an address by the late Dr. H. N. Guernsey, gives some valuable statistics taken with conscientious care from reliable sources.* "In allopathic treatment of puerperal fever, phlebitis, phlegmasia alba dolens, etc., the loss within the puerperal month is thirty per cent. or three hundred per thousand. In Homœopathic treatment, pure and simple, in the same disorders, only two per cent. or twenty per thousand. In puerperal convulsions (real eclampsia), allopathic treatment has a mortality of twenty-five per cent. or two hundred and fifty per thousand. In homœopathic treatment, pure and simple, we have a loss of only one and a half per cent. or fifteen per thousand. In puerperal hæmorrhages post-partum, the allopathic fraternity sustains a loss of sixteen and three quarters per cent. or one hundred and sixty-six and two-thirds per thousand. The loss from the same disorder under homœopathic treatment, pure and simple, is only one-twentieth of one per cent. that is, one in two thousand. The average mortality from all causes, within the puerperal month, from allopathic treatment, is one per cent, or ten per 1,000. * * Our statistics prove beyond question, that our mortality does not reach one-fifth of one per cent. less than two in a thousand."

With such record before us, one cannot but place dependence on our homœopathic drugs. Two or three cases under my own observation, have presented points of such deep interest, I would like briefly to note them, although I regret with the first, being unable to give her later treatment.

Mrs. N. has light complexion and excellent health; is intelligent and bright, with active temperament, and marked freedom from nervous symptoms. Had had one child, labor natural, with the exception of severe laceration of the perineum. She had some

*See a treatise by H. N. Guernsey, M. D., read by invitation before the New York County Homœopathic Medical Society, November 13th, 1878, published in New York Medical *Times*, for January, 1879.

dropsical symptoms previous to parturition, but not serious. The perineum was repaired by a secondary operation. Her second pregnancy was natural up to September 11th, the beginning of her eighth month. She was away all summer, and on her return early in September, called me in to see if she was "getting on well." She then had some general dropsy and a troublesome leucorrhœa. These were all her symptoms. On the 20th she became very restless and nervous, not lying down a half hour all night. She suffered sharp pains in the region of the stomach, like indigestion. Nux relieved these symptoms, but her appearance at this time was not satisfactory. The dropsy was more marked, even sufficient to change the expression of her face. She complained of dimness of vision, light was clear to her, but objects were misty, "as if looking through water," was her comparison. This was the very fact, because an effusion of water was easily apparent over the whole cornea, and the ophthalmascope revealed marked infiltration. Apis[3] in water was administered. Her nights continued to be restless and distressed. On the 22d, her condition was alarming. The nervous symptoms and dropsy were increased. She could neither eat, sleep nor lie down. Her limbs were enormously distended, also abdomen and chest; everywhere the dropsy was severe. Heart action was turbulent, one hundred and forty pulsations or more *per* minute, and often beyond counting. The sounds were irregular, a marked click with the second beat; respirations were forty to sixty *per* minute, and agonizing. There was extreme tension of the body, the muscles were drawn like cords with the effort of gasping for breath. Her eyes were dry and glaring. She called constantly for air, but felt as if there was none to breathe; said she "must relax," the consciousness of extreme tension being so unbearable. Every joint was stiff, and she sat perfectly erect in a chair, with her feet slightly elevated. then, as the attack lightened, she would lean forward on something in front of her, and doze a few moments. There was slight relief in the morning, but after an afternoon doze, or in the night, the violence of the paroxysms was reached. The urine was loaded with albumen, some pus and blood, one pint was voided in the twenty four hours. The diagnosis was easy, "acute tubular nephritis, with irregular convulsive seizurs, complicating pregnancy." Lach-

esis was administered but with no apparent relief. Counsel was called, and premature delivery suggested, but not considered justifiable or safe. On the night of the 23d, she was taken worse, a physician within easy reach was summoned, who gave her first Nux for sharp pains, following the taking of a little nourishment, then succeeded with Apis. On the 24th, there was a slight change for the better. On the 25th, the convulsive paroxysms were less, but the patient showed signs of exhaustion, and the heart sounds continued bad. Face quite as puffed up, and weary, eyes staring. As the patient lived out of the city, and her friends were continually obliged to call in the neighboring physician, it seemed better to give up the immediate care of the patient to him, though I still held an interest in the case. Apis was the remedy mainly depended upon, in different potencies. On the 29th, she was better, and for two days continued to improve, so that she could lean back in her chair, and even lie down for a short time. On the night of the 30th, she had excruciating pain in the left lumbar region, which though prescribed for, was no better, until a sudden movement of the fœtus relieved pressure. The child, for three days previous to this, had shown no sign of life. The following day she had apparent labor pains for an hour, but they passed off. On the 2nd of October, at four o'clock in the morning, these returned, and an hour later the infant was born, one month before term. Though immediately summoned, the doctor did not reach the house until the head of the child was expelled. The infant was dead, and had been for several hours. No laceration occurred and the symptoms were relieved, all pointing to a rapid convalescence. This, however, did not continue, the uræmic symptoms were slow in yielding, hemiplegia occurred, and her condition was again critical. All yielded later to remedies, and she recovered her former health, though her speech returned slowly, and her brain for a long time did not act so quickly as previous to her illness.

The following case of a brave little English woman presents some points of interest.

Mrs. —, æt 23, married two years, mother of one child. Healthy, fair, ruddy, has had no serious sickness. At the date of this illness, August 1st, she had been in America two months, all

of which time she had suffered with diarrhœa; she was pregnant, her labor was due in October; the diarrhœa was not severe, but of a dysenteric type. In the latter part of July, when she sought advice, readily yielded to Mercurius vivus, which was clearly indicated. On Wednesday, August 8th, diarrhœa again occurred, but of a different character; the discharges were profuse, watery, exhausting and painless, and accompanied with vomiting. Her physician was not summoned until Friday, August 10th. Already her condition was appalling, it was scarcely possible to recognize her, she was cold, pinched, blue about the lips, eyes sunken, face bathed in cold perspiration; the emaciation was extreme. An ordinary sized bucket was full of a brown, offensive liquid, which had passed her bowels during the previous night. Every article of food or drink was instantly vomited. She suffered from intense burning of mouth and throat, which were swollen, red, and angry in appearance; the entire mucous membrane felt as if raw, and looked so. The burning in her stomach was as if some violently acrid or corrosive substance had been swallowed. That the patient was laboring under a profound poison of some sort was apparent, and from the acute local symptoms, the possibility of an overdose of a strong drug was suspected, either accidentally or wilfully taken. She had been discouraged, because they had not prospered in this country, was home-sick, and distressed at the prospect of another child—but from the closest questioning, there seemed no evidence of such a cause. Then investigation was made as to poisoning from tin cans, etc., but no light was thrown on the case. A careful vaginal examination was made, but with negative results, there was a scant, pus-like discharge, with a rather heavy odor, from the vagina, but no other evidence that the fœtus was giving rise to the trouble. The patient thought she felt the child move, but this was questioned at the time. The indications for various remedies were marked, Caus., Phos., Ars., Bell., Verat., were thought of in rapid succession, but Veratrum was administered; it modified the discharge from the bowels. After this, Ipecac relieved the vomiting, which had not yielded under Verat; but her condition was not encouraging, the weakness and prostration continued. Milk was the only nourishment taken, and it was but seldom retained. She would not speak unless spoken

to, noticed nothing, cared for nothing. Swallowing was accomplished with great effort, owing to the swollen and sore condition of mouth and throat. She appeared almost comatose. At this stage, Arsenic was administered and continued. The cold, pinched face, the dry, burnt condition of mouth and throat, with the persistent burning in the throat, and other symptoms, decided the choice. From this period until her ultimate recovery, no other remedy was needed, except at one time Belladonna as indicated, but the main reliance was placed upon Arsenic. Her friends gave up all hope of her recovery, had the priest brought, altar set up, candles burning, etc. This general condition continued for about two weeks, with the daily thought that an abortion might occur at any time, then came a change for the better, slight, but perceptible. She noticed what was going on about her, the drawn expression passed away, and "a look of life came over her." The next gain was her asking for food; only milk, broths, and cold water had as yet been given. In ten days from this date, she had so far recovered, as to move about the house, go down stairs, and even walk out in the air a few times. On the last day of August, while sitting comfortably in an easy chair, and counting herself well, without pain or other premonition, she passed a dead fœtus, with all the appendages, in an entirely decomposed state. It appeared about five months, as far as was discernible, but the condition prevented much examination. It was, as the nurse termed it, "a great rotten mass." She was hastened to bed. The lochia was natural, there was milk in the breasts, no unfavorable symptoms occurred, and she made a rapid recovery.

THREE CASES OF EXTRA-UTERINE PREGNANCY.

BY J. ARTHUR BULLARD, M. D., WILKES-BARRE, PA.

Feeling that extra-uterine pregnancy, is a condition, owing to its comparative rarity, not fully studied or well understood, and having had the good or bad fortune, to have had a greater number of cases than usually falls to the lot of a general practitioner, I have felt it a duty to report them.

Certainly no graver complication of pregnancy can happen to women, or one more terribly fatal in its results, than that which places the product of conception outside the receptacle intended by natural laws to be its resting place, until such time, when by proper development, it is fitted for an independent and separate existence. If, therefore, we can establish data and give information that may prove of value in diagnosing, and safely treating such conditions when they are suspected or proven to exist, we will be accomplishing much, for no one can tell at what time just such a case may fall into his hands for treatment.

I do not, in reporting the following cases, claim to have exhibited any superior intelligence or skill in diagnosis or treatment, but no doubt it will be cheerfully conceded by all, that so far as results go, I have been favored, with what might be called extra good fortune. With these few introductory remarks, I will call your attention to

Three Cases of Extra-uterine Pregnancy.

Case I.—Mrs. E, æt 25 years, the mother of one child, born four years previous, came under my treatment for menorrhagia—due to chronic endometritis—January 1883, at which time she presented the following prominent symptoms: Repeated attacks of too frequent, too profuse, and too long lasting menstruation, accompanied latterly by a great deal of pain and uterine tenderness. There was marked emaciation and debility with depression. An examination made at the second visit, found the mouth of the womb soft, patulous and open, the cervical canal blocked with thick purulent mucus. The uterine cavity, which was sensitive, and bleeding at the slighest touch, measured nearly four inches in length, and on the posterior lip was a deep angry-looking ulcer, as large as a dime, whose irregular edges strongly suggested malignant origin. Under thorough extra and intra applications, weekly, of phenic acid, sub-nitrate of mercury, hydrastis, iodine, calendula and glycerine, and the daily douching with hot water and solutions of hydrastis, by means of a fountain syringe at her home, together with the internal administration of Ars. jod., Hyd., Kreos., Actea. rac., and Trillium, she made rapid progress, and

by May following, the menstrual function was well and properly performed, the uterine measurement reduced to less than three inches, the ulcer healed, and the long lasting catarrhal inflammation, a thing of the past, with my patient on the broad road to perfect health.

In July, she ceased to menstruate, and began September 15th, to have a peculiar and, at times, severe pain in the left ovarian region, which, however, lasted only between the hours of three and seven P. M. of each day, and during this period of time, it would start from the ovary and extend through to the back in great severity, and was accompanied by a feeling of numbness in both lower limbs. After giving the case much thought and study, I began to strongly suspect that it was a case of tubal pregnancy, and so described it to the patient's husband, at once advising great care in the avoidance of over-exertion, suggesting the recumbent position, and giving such remedies, from day to day, as the various symptoms seemed to indicate.

On October 3, at 2 A. M., she was taken suddenly and alarmingly ill with a most agonizing pain in the abdomen, accompanied with violent vomiting. I was sent for at once, but owing to severe illness in my own family, I did not arrive at the bedside until six hours later, when I found her in a state of collapse, bloodless and pulseless, and only an occasional fluttering of the heart to betoken that she was not absolutely dead. Before my arrival, they had forced a few drops of brandy down her throat, applied mustard plasters, and surrounded her with fruit jars filled with hot water, which were changed at the slightest suspicion of coolness. Notwithstanding this, the body remained quite cold, and there was every indication of an internal hæmorrhage to a degree that speedy dissolution seemed inevitable. Willing hands were not wanting, however, and after several hours we were rewarded by being able to detect a slight fluttering at the wrist, and evidence of returning vitality, as shown by an occasional sighing respiration. It was four days before she recovered consciousness, after which she slowly improved in strength and color, sitting up in bed for the first time on the 25th day of November following, The improvement, though necessarily slow, was constant, and the menses made their first appearance during the latter part of December, and have

continued regularly since. The patient has been in excellent health from that time to the present writing.

This case I diagnose as one of tubal pregnancy, with rupture in the second month, the product escaping into the abdominal cavity, and eventually becoming encysted.

I do not know that the case just reported is one of especial value, only so far as the symptoms given might aid in the diagnosis of a future similar case. As far as treatment was concerned, I at that time knew of no operation that could have been justified under existing circumstances, nor did I know the "indicated remedy." Now, if called upon to treat a similar case, I should feel more equal to the emergency, and should depend, with all confidence, upon the application of electricity, used with sufficient intensity to destroy the life of the precocious wanderer, any good faradic battery being abundantly sufficient for that purpose.

If, however, the time should come when an accurate, differential diagnosis is possible between a strictly tubal or abdominal pregnancy, like the one just cited, and a tubo-uterine or possibly interstitial pregnancy, an illustration of which will be given under Case II., the indication for treatment will be plain beyond question; namely: to kill or destroy the product of conception proven to be tubal, by the electric current; and use every legitimate means at your disposal, to facilitate the removal of the fœtus from its adjoining cavity to the womb proper, there to fullfil its mission.

Case II.—Mrs. L., a lady of lax muscular fibre, æt. 32 years, married thirteen years, the mother of four children, the youngest being three years old, consulted me September 22, 1884, at which time she complained as follows:

Pain in right ovarian region, extending to the hip of same side, and a general feeling of discomfort through the entire pelvic viscera. On examination, I found the uterus enlarged, tender to the touch and considerably retroflexed. The cervix was inflamed, and the os as large in diameter as an ordinary lead pencil, was full of tenacious mucus. As she had missed one menstrual period, I examined her with great care, and after partially correcting the mal-position and applying a tampon of cotton, wet with a solution of quercus alba and glycerine, dismissed her, with instructions to

report in three days. At the second examination made September 26, I thoroughly and easily explored the uterus, and found it empty; the sound entered the cervix, with the greatest ease and could be manipulated in every direction without resistance, and the examination, notwithstanding its thoroughness, was not, except in a slight degree, painful. The inflamed and sensitive condition of four days previous having, to a great extent, disappeared, I advised hot water injections, and prescribed Actea rac.^{3x}, a dose every four hours, and requested her to report her condition later.

The following week gastric disturbances, similar to those noticed in the first months of pregnancy, became somewhat annoying, but under the use of indicated remedies, and such local measures as seemed necessary, were much modified, and gradually disappeared.

About the third month, however, a suspicious swelling made itself known, more prominent to the right of the median line, and not sufficiently well defined to locate absolutely, and erratic as well, inasmuch as it would be noticeable one day and wanting the next. The breasts also began to increase in size, and, in fact, everything began to indicate, to a greater or lesser degree, the pregnant condition.

Notwithstanding all this, repeated and careful explorations of the womb failed to discover the presence of an intruder, and the symptoms above enumerated continuing, I now came to the conclusion that a tumor of some description had located to the right of the uterus, possibly attached to it, and by enlargement and presure had set up an irritation sufficient to elicit the existing symptoms which ordinarily would very strongly indicate the pregnant state.

This enlargement would, however, vary in size so much, from one examination to another, as to make a positive diagnosis extremely difficult. So, acquainting my patient's husband with all necessary facts, I requested and obtained his consent to a consultation, and in November, we took her to Philadelphia to see Dr. C. M. Thomas. Finding the Doctor disabled by a dissecting wound of finger, and consequently unable to make the necessary examination, we called in Drs. A. R. Thomas and J. N. Mitchell, the former not excelled as a general diagnostician, and the latter

a gynæcological specialist of acknowledged ability. Both made careful examinations, and both pronounced the uterus to be empty. The enlargement noted before was provokingly less noticeable than usual, and as neither of the consulting physicians felt warranted in committing themselves to a positive diagnosis, we returned home, not greatly wiser than when we came. Dr. Mitchell, intimating, however, that the location of the trouble appeared to be in the right fallopian tube, near its junction with the womb. After returning to her home, the tumor became more prominent, and gradually it was more evident that it was becoming part of the uterine body. It was also not infrequently the seat of sharp pains. About the middle of December the patient became cognizant of a fluttering sensation similar to that first noticed about the fourth month of gestation. She became very much depressed, and suffered greatly at times from an aggravation of the old gastric troubles. I now, for the first time, began to be reasonably positive that I had a case of interstitial, or extra-uterine pregnancy to deal with, and, recognizing the gravity of the case, felt that I was justified in adopting active measures for relief. Local treatment was accordingly resumed. The womb thoroughly dilated, large tampons were placed therein; applications of caustic potash and glycerine freely made on right uterine wall, which could, before long, be noticed to encroach decidedly on the true uterine cavity, as sloughs were formed by its action. The pain caused by this treatment was considerable at times, but was never beyond the strength and courage of the patient to endure.

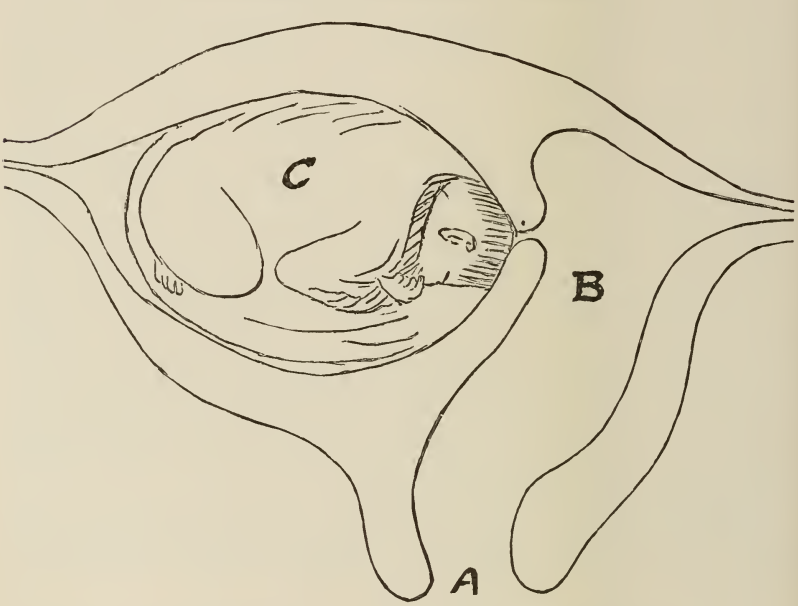
While the way the organ involved, tolerated this heroic treatment was truly wonderful and commanded my admiration, it could not but daily excite my fears.

This treatment was continued, with slight variations, until February 1, when, so far as could be determined, the enlargement seemed to be a well-defined portion of the right uterine wall, and the general condition of the patient much improved.

On February 15 I was sent for shortly after midnight, and on my arrival found my patient suffering with well-marked labor pains. On examination, I discovered, well up in the uterine cavity, what proved later to be a fœtal head, for in comparatively a short time I succeeded in delivering her of a fœtus weighing $4\frac{3}{4}$ pounds,

the placental membranes following nicely soon after. An examination made at this time determined the existance of a compartment or fœtal sac, which had doubtless developed in the uterine end of the right fallopian tube, presumably half an inch or less distant from the womb proper, but later, by development, had become an annex, so to speak, of the uterus itself, so that by gradual absorption of intervening tissue, what was at first extra-uterine became ultimately, by rupture of dividing septum, intra-uterine pregnancy, followed naturally by labor and expulsion in a natural manner.

DIAGRAM ILLUSTRATING CASE II.



A.—*Os Uteri.* B.—*Uterine Cavity.*
C.—*Child in fœtal sac made by development of Fallopian tube.*

The hæmorrhage was not greater than in many ordinary deliveries, nor was the patient's recovery marked by any especially untoward symptoms. Solutions of permanganate of potash were used twice daily for ten days. A greater sense of pain and soreness was noticeable for some time through the entire abdominal viscera. By the expiration of the third month, the menses reap-

peared, and the patient has been in her usual health from that time to this writing.

This case I diagnose as one of tubal pregnancy changed to uterine by combined natural and artificial means, with the result of saving a life which, had it been left to the unaided efforts of Nature, might, certainly, have reached a fatal termination. A case surely of unusual interest, inasmuch as it was seen to a successful issue, and that it goes to establish what is not usually admitted, namely, that, under such circumstances, the womb will tolerate a more aggressive treatment than the generality of practitioners have supposed, and that, too, without any undue resentment or danger.

Case III.—On May 10, 1885, Mrs. W., a comely looking widow, æt. 40 years, of Caucasian parentage, but living in concubinage with a coal black negro, came to my office to consult me in reference to a gastric trouble, and incidentally mentioned, in the course of questioning, that she had long been a sufferer from diseases peculiar to her sex. As she was somewhat deaf and inclined to be reticent, I did not, at this time, elicit any especial symptom bearing on her female weaknesses, save that she had not menstruated for five months. She did not report the result of my prescription, and I did not see her again until the following November, six months after the visit mentioned. I was then called to the house to prescribe for a hæmorrhage, which she had wrestled with but had been unable to control, but which had prostrated her greatly. On examining her abdomen, at her request, I discovered an enlargement in the right of the hypogastrium, which was irregularly globular in form, as large as a small child's head, and hard and unyielding on pressure. The impression conveyed to my mind at the time was that it was a uterine fibroid.

The hæmorrhage for which I had been called had grown noticeably less after sending for me, and was soon under control and the patient reassured, so that when I called the following day it had entirely ceased, and she was sufficiently comfortable to give me the following history:

In January, 1885, she had ceased to menstruate, but owing to previous irregularities this occasioned no alarm until, not long after, she began having slight pains through the womb, which continued in a bearable degree until April, when they increased to the

extent of frightening her into consulting a physician, who pronounced her disease gall-stone colic, and prescribed morphia. After this she continued to take morphia *ad libitum*, whenever the pain was severe.

In May, she first noticed an enlargement or swelling in the abdomen, which, being more pronounced over the seat of pain, excited her apprehension, and she again consulted her physician, who, after examination, pronounced her suffering from fibroid tumor of the womb, and advised her to place herself in the hospital, preparatory to having it cut out. This she fortunately refused to do, having a great dread of hospitals. Shortly after this, she began to feel a throbbing through the tumor, which created an impression in her mind that possibly she might be in the family way after all. So, having lost confidence in her last medical adviser, she sought another, who, after examination, scouted the baby idea as not tenable, and assured her positively that the trouble was undoubtedly a tumor, and the knife was the only remedy. He afterward brought counsel, and both urged the hospital and an operation, but to no avail. She was willing to undergo the operation, but refused to enter the hospital, while the physicians very wisely concluded not to operate at her home. The pains in the meanwhile having grown more and more unbearable, the morphia became more and more necessary, and was taken freely and frequently, until one day about the middle of July, her distress becoming intolerable, she took a much larger dose than ever before, and from that date to the finish she had no further throbbing or sense of pulsation in the abdominal tumor.

As near as I could ascertain, it was a month or six weeks after the cessation of motion that she was taken with a violent chill, followed by lancinating pains through the bowels, vomiting, great abdominal distension, difficulty in breathing, in fact, a reasonably good picture of a severe attack of inflammation of the peritoneum, and from such data as was obtainable from those with her at this time she was presumably a very sick woman for several weeks, but finally succeeded in regaining strength sufficient to crawl out of bed in a state of almost hopeless invalidism, a picture of emaciation, pain, feebleness, and great bodily distress. This condition continued with slight variation, until the 19th of March, when she

was again taken with violent pain in the bowels, and sent to me for medicine.

On the following day a neighboring woman came hurriedly to my office, and told me that Mrs. N. would certainly die if not soon relieved, and begged me to come at once.

As soon as possible, I took my operating case and drove to her house, and found her in great agony with the pain, referred almost entirely to the rectum, and was informed by her daughter that she had not had a passage of the bowels for more than a week. Annointing my finger with carbolated oil, I introduced it well into the rectum, and could find, as high up as I could reach, what I cannot better describe than by saying it felt like a mass of broken china, tied up in a bladder, completely blocking the passage. Using my finger as a guide, I made at once an exploratory incasion into this sack, and was rewarded by a gush of positively *the* foulest combination of overwhelming stench that ever came in contact with human olfactories. Determined, however, to die on the field if necessary, I continued in the breech, as it were, and by means of fingers and dressing forceps, succeeded in extracting the skeleton of a six month's fœtus, most of which I offer for your examination.

Simultaneously with the evacuation of this extra-uterine cyst, the tumor disappeared, and a few moments after, a tremendous train of fæcal accumulation thundered down the gorge, and my patient was soon sleeping from relief, as well as exhaustion. The hæmorrhage was slight, and after washing out the rectal sac with permanganate of potash frequently and thoroughly, with the internal use of Secale and Arsenicum, the patient made a phenominally rapid recovery, without a symptom of septic poisoning or a higher temperature at any time than 101°, which was registered on the second day.

Two days later, on inquiring at my morning visit how she had enjoyed her toast and tea this morning, I was informed that she had tired of "slops," and that fried ham and eggs and warmed over cabbage, had constituted her delicate repast, washed down by a pint or so of muddy coffee, and also that the invalid herself had walked out into the shanty to superintend the preparation of the viands named, and all this mind you, days before the odor of

the engagement (figuratively speaking) had disappeared from my hands, hair and clothing. She did not pay any penalty, however, for her rashness—nor did she pay her physician for his attendance—but has made an uninterrupted recovery to a condition of robust health.

This case was one of tubal or abdominal pregnancy, in which the fœtus was killed about the sixth month, by an overdose of morphia taken to relieve acute pain. After which through irritating pressure and peritoneal inflammation, bands of adhesion were no doubt formed between the fœtal sac and the rectum, resulting in a gradual thinning process or absorption of dividing wall, until by pressure and gravity, it pouched into the gut, closing all communication and necessitating operative interference.

A CASE OF PUERPERAL SEPTICÆMIA.

BY J. RICHEY HORNER, M. D., ALLEGHENY CITY.

Mrs. I. M. G—, æt 19 years,—Primipara—March 1st, 1886, called at 6 A. M. Mrs. G. has been having severe pains since midnight, coming at short intervals, though not regular. On examination, I found the os uteri dilated to the size of a silver dollar, hard and rigid. After a time, the pains became more regular and efficient. Head engaged in the first position. This was about 9 A. M. At 1 P. M., the head had made no further progress, and on examination found that it was tightly wedged in the pelvis, which is an abnormally small one. Called Dr. Wm. R. Childs in consultation, and he applied the forceps. Delivery was now effected, but at the expense of a rupture which involved the entire perinæum and the sphincter ani.

Delivery of the placenta was next accomplished. This was followed by profuse hæmorrhage which was effectually controlled by Cinnamon℞.

Immediate operation for ruptured perineum was decided upon. Ten silver wire sutures were applied, being placed deeply and at short intervals. The vaginal sphincter was brought in apposition by carbolized silk sutures, eight being used.

After treatment consisted of a dressing of a two per cent. solution of carbolic acid and warm water and douche of same, morning and evening. Light diet was ordered and perfect rest and quiet. ℞ Bell.^{3x} every hour.

During the following week, the patient progressed well—nothing unusual to such a severe case having occurred.

At six A. M. of the eighth day, however, she had a severe chill which lasted nearly an hour, and was followed by high fever. At 10 A. M., the temperature was 106°; pulse 136. ℞ Ver. vir.^{0} every one-quarter hour.

The temperature varied during the day, the lowest being 103°; the highest 106°. There is perhaps a slight diminution in the amount of the lochial discharge which is not offensive, nor is it abnormal in color. Ver. vir.^{0} continued at intervals of one-quarter to one hour.

March 9th.	6 A. M.	Temperature	$102\frac{3}{5}$°.	Pulse	110.
"	12 Noon.	"	102°.	"	104.
"	6.30 P. M.	"	$104\frac{4}{5}$°.	"	110.
"	9 P. M.	"	$105\frac{2}{5}$°.	"	120.
"	12 P. M.	"	$104\frac{2}{5}$°.	"	120.

The lochia became more free early in the day but were quite offensive. Has slight throbbing headache and flushed face. No pain or tenderness about the perineum or through the abdomen. ℞ Bell.^{3x}, Ver. vir.^{0} alternately every half hour. Locally, douche morning and evening of $\frac{1}{2000}$ solution of bichloride of mercury.

March 10th,	6 A. M.	Temperature	104°.	Pulse	110.
"	12 Noon.	"	$105\frac{9}{10}$°.	"	120.
"	3.30 P. M.	"	$106\frac{1}{5}$°.	"	136.

At the suggestion of Drs. J. H. McClelland and Childs, prescribed Chininum ars.^{3x} every hour. Vaginal douche as above every two hours.

4 P. M.	Temperature	106°.	Pulse	119.
6 P. M.	"	105°.	"	116.
12 P. M.	"	$104\frac{2}{5}$°.	"	120.

Lochial discharges have been quite offensive. To-day the stitches were removed from the perineum and good union found to have taken place. There is little or no redness about the parts Treatment continued.

March 11th,	6 A. M.	Temperature	$103\frac{2}{5}°$.	Pulse	110.
"	12 Noon.	"	$99\frac{3}{5}°$.	"	102.
"	6 P. M.	"	$99\frac{4}{5}°$.	"	95.
"	12 P. M.	"	$100\frac{1}{5}°$.	"	98.

To-day, has had two passages from the bowels; involuntary, dark, scanty, and very offensive. Lochia slight and of foul odor. Has been restless, thirsty and wakeful. In the early morning was slightly delirious. Has taken but little nourishment. Treatment continued.

March 12th.—At 1 A. M., feverish condition began and increased until at 9 A. M. temperature was $105\frac{1}{2}°$; pulse 120. Gave Chin. ars.^{2x} every half hour until 1 P. M., when the temperature was 103°; pulse 108. Continued remedy in 3^x every hour until 5 P. M., when, temperature rising to 104°, the 2^x was again given every half hour.

6 P. M.	Temperature	$104\frac{1}{2}°$.	Pulse	116.
9 P. M.	"	105°.	"	120.
12 P. M.	"	$103\frac{1}{5}°$.	"	110.

Has been very restless all day, and slightly delirious. Urine decreasing in quantity, dark and very offensive. Treatment continued.

March 13th,	6 A. M.	Temperature	$102\frac{4}{5}°$.	Pulse	110.
"	12 Noon.	"	101°.	"	106.
"	6 P. M.	"	$102\frac{1}{2}°$.	"	109.
"	12 P. M.	"	$102\frac{1}{5}°$.	"	98.

To-day has had three involuntary stools, rather more natural than the previous ones; not so offensive. Lochial discharges becoming more normal. Has slept some and has not been delirious. Treatment continued.

March 14th,	6 A. M.	Temperature	$101\frac{1}{5}°$.	Pulse	102.
"	12 Noon.	"	98°.	"	88.

In consequence of depression and exhaustion, gave, every three hours in alternation with Chin. ars.^{3x}, a stimulant consisting of Camphor tincture, one drop, to the drachm of sherry wine. Gave also egg-nog and Cibil's extract of beef every three hours. This had the desired effect. The temperature having risen to $101\frac{3}{5}$ pulse 101, at midnight, the stimulant was then discontinued.

March 15th,	6 A. M.	Temperature	100°.	Pulse	98.
"	12 Noon.	"	$102\frac{2}{5}$°.	"	110.
"	6 P. M.	"	$103\frac{2}{5}$°.	"	110.
"	12 P. M.	"	$103\frac{1}{5}$°.	"	104.

During the day has been feeling quite comfortable. Is not suffering any pain. There is no pelvic tenderness. Lochial discharges slight and somewhat offensive. Treatment continued.

March 16,	6 A. M.	Temperature,	101°.	Pulse,	100.
"	12 Noon.	"	$101\frac{1}{5}$°.	"	100.
"	6 P. M.	"	$101\frac{3}{5}$°.	"	100.
"	12 P. M.	"	$103\frac{4}{5}$°.	"	106.

To-day the diet has been free and stimulating. There has been no appreciable change in the condition of the patient. Treatment continued.

March 17.—Complained to-day of pain and soreness in left hip. On examination, found the parts swollen, hot and red. Applied lotion of ten per cent. solution extract Belladonna. General treatment continued.

March 19.—During the past two days, until four o'clock this afternoon, the patient was progressing nicely. At that time, she complained of chilliness, which lasted half an hour, and was followed by elevation of temperature, the thermometer recording $106\frac{3}{5}$° at seven o'clock. Chin., ars.^{3x} every half hour was prescribed, with very perceptible effect, the temperature at midnight being $104\frac{2}{5}$°; pulse, 110. There is no change in her general condition, and nothing can be discovered which would account for this fever. After 10 P. M., the remedy was given every hour.

March 20.—To-day, the reaction came, the temperature rapidly falling, until at midnight the record showed only 98°, pulse being 90. It was found necessary to give several doses of the stimulant of sherry wine and tincture of Camphor. She has seemed to be very much exhausted, having been drowsy all day.

March 24.—For the past three days the temperature continued low, despite the very generous diet and stimulants prescribed. The lowest point—$96\frac{3}{5}$°—was noted at 3 A. M. to-day. Artificial heat was applied to the extremities, the wine was given freely, and with it egg-nog and Cibil's extract of beef. At 3 P. M. reaction began, and at 6 P. M. the temperature was 102°; pulse, 100. The

stimulants were then discontinued, and only the remedy, Chin. ars.^{3x}, given.

March 30.—There has been nothing worthy of note occurring since above date. To-day, at 1 A. M., Mrs. G. was attacked with a severe chill, which lasted half an hour, and was followed by the same extreme rise of temperature as was noted a week or more ago. The record is as follows:

3 A. M.	Temperature,	$103\frac{3}{5}°$.	Pulse,	100.
6 A. M.	"	105°.	"	120.
9 A. M.	"	106°.	"	126.

Up to this time she had been taking Chin. ars.^{2x} and Bell.^{3x}, alternately, a dose every half hour. Now, I changed the prescription and administered Acon.^{3x} and Bell.^{3x}, as follows: Acon.^{3x} at intervals of a half hour until four doses were taken, followed by Bell.^{3x} in the same way, and resuming the Aconite^{3x} after four doses had been given. This had the desired effect. At

11 A. M.	Temperature,	$105\frac{9}{10}°$.	Pulse,	125.
1 P. M.	"	$105\frac{4}{5}°$.	"	123.
6 P. M.	"	105°.	"	120.
11 P. M.	"	104°.	"	115.

This aggravation, like the others, was not to be explained by any appreciable condition of the patient. She had been progressing rapidly towards convalescence, had been suffering no pain, and was apparently in excellent condition.

March 31.—Reaction was manifest to-day, the temperature being nearly normal at midnight. From this time until she was discharged cured, there occurred no more febrile disturbances, the temperature at no time rising above 100°.

In this case Chin. ars., in the second and third decimal triturations, was very effective in controlling the temperature.

HÉGAR'S SIGN OF EARLY PREGNANCY.

BY J. NICHOLAS MITCHELL, M. D., PHILADELPHIA.

To the obstetrician, and gynecologist also, it often becomes a matter of the utmost importance to be able to determine preg-

nancy in the early weeks. The impossibility of determining this fact at such an early period has been termed the opprobrium of the obstetrician, and most authorities have stated in the past that a positive diagnosis of pregnancy could only be determined by the sounds of the fœtal heart.

To arrive at some certain sign then, has been the constant study of many, but though many signs have been discovered, none of them has been found invariably correct in all cases, unless this new one proposed by Hégar will bear the test of many investigations. Like the symptom of absence of menstruation, others, such as the discoloration around the nipples, the kyesteine in the urine, and the slate or purplish color of the vagina, have been found to be simply presumptive signs, since, unfortunately for the purposes of diagnosis, they are found in other conditions besides that of pregnancy.

Again, other methods that have been proposed and not practicable in general practice, such as the proposal to apply the principles of the telephone, so as to hear the feeble sounds of the fœtal heart earlier than can be done by the ordinary method.

Others have proposed methods which are too dangerous to follow, even if the certainty of the test be allowed, such as Gehrung's proposal to pass the sound into the uterus, to recognize thereby the sensation imparted to the instrument when it touches the fœtus; or Fry's discovery that the temperature of the cervix is one degree or more above that of the axilla during pregnancy. If this same variation was found to occur between the vagina and axilla it would be a useful sign, but unfortunately such is not the case. There is too much risk in passing anything into the cervix, however, to even put this sign to any great trial. The sign which has been offered by Hégar has, so far as my reading goes, proven of more value than any other, since all who have written upon it and have learned to recognize it, are enthusiastic about it.

Dr. Reiul, formerly assistant to Hégar, says, in twenty-two cases it was missed but twice, and discovered as early as the fifth week.

Dr. Compes, assistant to Hégar, has reported six cases.

Dr. E. H. Grandin says: "I am inclined, from a limited experience, to consider it infallible." He reports eighteen cases. Dr. E. S. McKee reports two cases. In one, from the absence of this

sign, he made a diagnosis, which time proved to be correct, that the patient was not pregnant, and in another, diagnosed pregnancy by the presence of this sign.

To these, I have to add nine cases where I found this sign present and where I diagnosed pregnancy, and time has proven these diagnoses correct. In two of these, pregnancy was not at all thought of, nor was this sign particularly sought after. This has made it, to me at least, a symptom of greater value, since often when one is looking for a peculiar sign or symptom, and has his suspicions aroused, imagination plays a great part.

Besides these, there were two others of great interest. One of them had gone two weeks over her time, and supposed herself, from that alone, to be pregnant. During my absence from the city, she was taken with severe flooding when in the street. Finding me absent from the city, she sent for an allopathic physician, who checked the hæmorrhage, and said that if she had been pregnant before, she certainly was not so after this hæmorrhage. Upon my return home, a week later, she sent for me, and finding this sign of Hégar's present, I diagnosed from that alone that she was pregnant. In a week's time, she had another severe hæmorrhage, which was likewise stopped, and since then there has been no further trouble, and time has proven that she was pregnant.

In another case, a physician brought his wife to me for examination. She had passed her period but a few weeks. He said that he was sure that she could not be pregnant. I examined her, but could decide nothing. She had no symptom to go by except the absence of menstruation. I advised him to bring her to me again a few weeks later, which he did, and then informed me that he had passed the sound into the uterus since I had made the first examination, as both he and his wife were sure that she could not be pregnant, that a week had gone by, and that as yet she had no discharge. She had none of the usual signs of pregnancy. Her breasts had not changed in color; she had no nausea nor any other symptom. Upon vaginal examination, I found Hégar's sign, and by it alone diagnosed pregnancy. Some two weeks afterwards she miscarried.

It is not necessary to go into the details of all the cases; it is sufficient to say that the diagnosis of all of them was made between

the fifth and eighth week. Since it may have happened that the description of this sign has been overlooked by some, I have thought it well to describe it.

During the first few weeks of pregnancy all the change that occurs in the uterus, occurs in the body. From the hyperæmic condition of the uterine body, due to the attachment of the impregnated ovum, it enlarges, and this enlargement is most marked in the antero-posterior diameter; furthermore, the density of the uterus becomes markedly decreased to the touch. As a result of these changes, the uterus loses its usual pear shape; the outline of the body is no longer that of a gradual curve from the fundus, lessening gradually as it approaches the cervix; on the contrary, as Grandin expresses it, "the body bellies out over the cervix in all the transverse diameters, in particular, antero-posteriorly, and the organ, instead of being pear-shaped, resembles very much an old-fashioned, fat-bellied jug."

Of course, to determine these changes in the uterus by the touch, requires more or less familiarity with the feeling, shape and size of the non-pregnant uterus, and also with the uterus when changed by disease.

The finger will generally note it best in the anterior cul de sac of the vagina, the sudden bulging out of the body around the cervix being most readily noticed there, from the normal anteversion of the uterus. The other hand being placed upon the abdomen and the uterus felt between the two hands, the softened resilient condition of the uterus will be felt, the slight sign suggestive of fluctuation. Of course, to be perfectly satisfactory, it is best to empty the bladder before attempting the examination.

PUERPERAL FEVER—CLINICAL CASES.

BY S. W. S. DINSMORE, M. D., SHARPSBURG, PA.

The appended cases are submitted without comment, as no adequate cause can be assigned by the writer which would produce this disease, so puzzling to the physician and generally so fatal to the patient.

During the early part of March I was called to attend but two obstetrical cases, a primipara March 4th, exceedingly difficult to deliver. It was impossible to prevent the small forceps from slipping, and after the second attempt I applied Wallace's long forceps, and with no little exertion delivered the child.

Four days later there was considerable metritis, which, with hot applications and the indicated remedies (Bell., Cham., etc.), gradually subsided, the patient making a complete and rapid recovery.

The second case was natural, and recovered promptly without medication.

At 2 A. M., April 31st, delivered Mrs. W. of a male child, her first confinement, followed by prompt recovery.

At 8 P. M., of the same day, delivered Mrs. B., æt. 25, of her second child. Labor lasted about one and one-half hours. Both mother and child seemed in good condition, and remained so until Sunday, May 2d, when she took a chill, followed by a raging fever. Temperature, 104°, discharges, etc., suppressed. When discharges reappeared, they were very offensive, great distention of the abdomen, sharp lancinating pains, which condition continued until death, which occurred at 11 A. M., May 11th. The patient was of good constitution, and had a history free from hereditary predisposition to disease.

At 1:15 P. M., May 1st, delivered Mrs. McD. of a female child, weight twelve pounds. Labor natural; shoulders difficult to deliver; no other difficulty attending. Next morning, Sunday, she began to vomit green, offensive matter, with simultaneous movements of the bowels. Matter thrown up changed to a yellowish hue, still offensive; pulse became rapid and feeble; temperature ran up to 105°, with alternate chills and hot sweat. Tympanitis came on rapidly, with delirium, gritting of the teeth, eructation of wind, and occasional vomiting of greenish-yellow, bitter fluid. Although carefully nursed and having apparently the indicated remedies, she grew rapidly worse, and died at 6 P. M., May 11th, five days and three hours after the child was born.

Sunday, May 2d, Mrs. V., a delicate, fair-haired and fair-complexioned woman, was delivered of her third child. Labor tardy but natural. With the exception of a slight engorgement of the breasts, a very satisfactory recovery.

Monday, May 3d, 2:15 A. M., Mrs. B., a healthy, fully matured woman, was delivered of her first child. Labor natural, lasting about one hour after the rupture of the membranes. Monday night, had chills, followed by vomiting of greenish, bitter fluid. Temperature 105°, reaching this point but one other time. On the evening of the 6th had nervous twitchings, excessive tympanitis, sharp, piercing pains, suppression of milk and lochia—a condition similar to that previously recorded of case number three. She died at 5 P. M. of the 8th, a week, lacking a few hours, from the time of confinement.

At 1:25 A. M., Mrs. K., a primipara, æt. 25, well developed, apparently in robust health, was delivered two weeks in advance of the time of expectancy. She had heard nothing of previously recorded cases. Labor normal, lasting about two hours; after-birth loose in vagina. At 10 A. M., Thursday, found temperature 102°, pulse 120; skin hot and bathed in sweat; discharge free, with considerable after pain. At 8 P. M., temperature 105°, pulse 148; nervous; belching of wind in large quantities; abdomen tympanitic and exceedingly sensitive to touch; pain under the ribs; timid and fearful; pulse never lower than 130 or temperature below 102°. Death occurred at noon of the 12th.

At 9 A. M., May 8th, Mrs. D. was delivered of her second child. After waiting fully one hour after the os was dilated, with no advancement of the head, the short forceps were applied, and very easily delivered of a very large child, being her second. She said the first labor lasted ten hours. Sunday, at 10 A. M., she began vomiting greenish fluid. Temperature 101°; fever; after pains, severe; discharge free; eructations of wind, with tympanitis; great thirst; hot sweat and quick pulse; bowels loose. Patient was tolerably easy, but the distention of the abdomen gradually increased. fever moderate until about 9 A. M. of the third day, when she began to vomit a greenish, watery fluid, continuing at intervals of a few minutes, until two chamberfuls had been thrown up.

At 9 P. M., skin cold; perspiration profuse; pulse at the wrist not perceptible; vomiting continued, nothing remaining on her stomach. Verat., Camph., Tart. emet., Ipecac., lime water, were given without any benefit whatever. Lochial discharge free, not offensive; tympanitis not great; temperature 96°;

Died at 7 A. M. of the 12th, lacking two hours of four days from the time of parturition, being the fifth death within ten days.

One case, number four in the order of delivery, making a complete recovery without any feverish or abnormal symptoms.

It may be added that, topographically, all were some distance from each other. No unsanitary surroundings can be assigned as contributing causes. All were treated antiseptically; the nursing, while not professional, was equal to the average family care usually given, and all in circumstances of life free from want or distress. In view of these facts, the writer confesses his inability to give a satisfactory reason for their simultaneous development.

Remedies used were Bell., China, Ars., Apis, Verat. vir., Verat. alb., Camph., Iris., Hyos., chiefly. All the children have since died.

A CASE OF PLACENTA PREVIA.

BY W. J. MARTIN, M. D., PITTSBURGH.

Early on the morning of June 22d, 1886, I was summoned in haste to Mrs. R. Upon arriving at the house I found the patient very pale and weak, and noticed that she yawned frequently. Was informed that she had been flooding profusely for several hours, a steady flow of bright red blood. I immediately administered a dose of Ipecac.[3] and in a short time there was a wonderful change in the condition of the woman. The color returned to the lips and face, her voice became stronger, and she said the flooding was "checking up." The history of this case is briefly as follows: She is now pretty near term; for three months back, she has been having attacks of hæmorrhage from the womb, occurring suddenly, unexpectedly, and without any provocation whatever, sometimes coming on while she was sitting quietly on a chair. The blood was always bright red, fluid. My diagnosis had been from the first placenta previa, and I looked forward to a serious time. She was very anxious to have a living baby (this was her first pregnancy) and I was very desirous of being the means of assisting in the accomplishment of the desired end. These frequently recur-

ring hæmorrhages were always speedily controlled by Millefolium[1]. The evening prior to my being called to her, the husband got medicine at the office, saying she had another of the flooding spells. I sent Millefol., which, I was told afterwards, stopped the hæmorrhage for several hours, but as it returned with greater severity and accompanied by pain, they thought best to send for me. I now made an examination, and found the os patulous and dilated to about the size of a half dollar, and the placenta presenting. By running my finger around inside the os, I could feel nothing but placenta anywhere except a narrow space on the right side, where, by considerable effort, I could reach high enough up to touch the fœtal head. Thus we were favored by not having a complete central implantation. My plan of proceedure was at once decided upon, viz.: to hasten dilatation by introducing my fingers in the shape of a wedge, and as soon as I could get the hand into the uterus, turn the child and bring the legs and feet out. A messenger was sent for my friend, Dr. Briggs, whose office, fortunately was not far distant. The Doctor quickly responded, and upon examining the case found the conditions as I have stated. After placing the patient in a favorable position, Dr. Briggs proceeded with the administration of the chloroform.

I found the introduction of my hand to be not very difficult, the grasping the feet and bringing them down was more so, but yet it was accomplished quite speedily; and here I had intended to let matters rest (as all hæmorrhage was at once stopped), and await further dilatation and expulsive pains, but I was surprised as well as vexed to find a coil of the cord around one of the legs, and it was not pulsating. Still my desire to make the result in the case the best possible, spurred me to try to get the child delivered at once. So wrapping a cloth around the ankles, to keep my hand from slipping, I steadily pulled as hard as I dared, until I had the body delivered, and here it seemed inclined to stick, until Dr Briggs, by placing his hands on the woman's abdomen, got his fingers down behind the fœtal head, and, as it were, expressed it from the uterus.

The child, we need hardly say, was pale and breathless, but its heart was still beating, though but slowly and feebly. Everything was in readiness, and while I looked after the mother Dr. Briggs

went to work with a will to resuscitate the child. He worked diligently and patiently but to no avail, the heart finally ceased to pulsate.

With the mother everything went well, and in two weeks she was up. The treatment in her case consisted simply of perfect quiet and cleanliness and the administration of the indicated remedies. Many, no doubt, would have used antiseptic injections, but this is a practice I have never pursued except when there were conditions present requiring it. The indiscriminate use of these injections, or their use in all cases, as advised by some, I cannot but think is useless, and sometimes, perhaps, worse than useless.

This is the second case of placenta previa that I have seen. The first case, which was some eight years ago, was managed after the manner directed by Guernsey in his work on obstetrics. The membranes were punctured by a catheter thrust through the presenting after-birth, and the liquor amnii drawn off. But instead of pains coming on, the little pain there had been, ceased, and the hæmorrhage was not modified in the least. The woman bled and bled. Stimulants and ergot were frequently and freely administered. The os dilated very slowly and the pains were almost nil. As soon as it was at all possible to introduce the forceps the placenta was torn and the child delivered in that way. It was dead. The woman was thought to be dead or dying, but she slowly rallied and made a very tardy, though perfect, convalescence.

The two cases lead me to the conclusion that the method by turning is by far the preferable one, though Guernsey, an author for whom I have great respect, says that "suffering entailed upon the women by this method, and the very great mortality of both mothers and children following its practice, sufficiently condemn it."

As regards the suffering, that can all be gotten over by the use of chloroform, and there is no reason why the mortality should be great, or hardly any to the mothers—of course, the child's chances are not extra good. And the statements that "almost invariably after placenta previa has been treated by the withdrawal of the liquor amnii through a catheter, the os uteri dilates in a natural manner until it is sufficiently enlarged to admit of the passage of

the child," and that as surely as the liquor amnii flows off slowly "so surely will the hæmorrhage cease," must, I think, be taken *cum grano salis.*

REPORT OF THE BUREAU OF GYNÆCOLOGY

Was presented, through the Chairman, Dr. B. F. Betts. It embraced the following papers:

A Fatal Case of Ovariotomy, by C. H. Hofmann, M. D., Pittsburgh.

A Case of Uterine Polypi, by R. P. Mercer, M. D., of Chester.

The Importance of Immediate Operation for Laceration of the Perineum, by Isaac G. Smedley, M. D., of Philadelphia.

Mechanical versus Medicinal Measures in Uterine Displacements, by Emma T. Schreiner, M. D., of Philadelphia.

Treatment of Sterility, by Harriet J. Sartain, M. D., of Philadelphia.

Dysmenorrhœa, by the Bœninghausen Club, of Philadelphia.

a. Dysmenorrhœa and Its Causes, by Joseph Hancock, M. D.

b. Treatment of Dysmenorrhœa, by George T. Parke, M. D.

The Application of the Principles of Homœopathy to Abdominal Surgery, by B. F. Betts, M. D., of Philadelphia.

A FATAL CASE OF OVARIOTOMY.

BY C. H. HOFMANN, M. D., PITTSBURGH, PA.

Mrs. Josephine A., æt. 39, was admitted to the hospital May 13th, 1886. She first noticed an enlargement in the abdomen ten years ago. This gradually increased, until now she is decidedly larger than in pregnancy at full term. For the past two years, she has complained of pain in the lumbar and in the pelvic regions. Fluctuation was distinct, and the tumor could be easily mapped out. The tumor filled the abdomen so much that no opinion could be formed as to whether it was adherent or not.

The operation took place May 15th, 1886, at 4 P. M. An incision was made from the umbilicus to the pubes, and this was sub-

sequently enlarged to several inches above the umbilicus. The hand was passed as far as possible between the tumor and the abdominal walls, but, owing to the large size of the tumor and the tense condition of the abdominal muscles, this could be done only to a depth of four or five inches.

The presenting tumor was tapped, and another one lying immediately behind the first one was disclosed. Owing to the fact that this second cyst was distinct from the first, almost as far down as the level of the superior strait, it was tapped separately, and then the gravest complications were found.

The upper posterior aspect was widely adherent to the omentum; the descending colon, lying somewhat behind the tumor, was adherent to it for almost the whole of its length, and both were fused with the parietes. The omentum was seared off from the tumor with the actual cautery, but in trying to separate the colon from it the bowel was torn into. Running the hand down toward the pelvis, it was found the tumor was adherent all along the superior strait, and separating these adhesions in one place, they apparently extended universally throughout the pelvis.

The cysts were now cut off low enough to be merged into one, and the walls being thick and vascular, the edges were stitched around with the continued suture, and the edges brought together. The tear in the colon was repaired, and the abdominal incision sewn up.

The wound was dressed in the manner usually pursued in the hospital. Iodoform was sprinkled over the line of the incision, and a compress of antiseptic gauze over this, then three or four strips of adhesive plaster, reaching well around the sides of the patient and thoroughly relaxing any tension on the stitches; over this a pad of cotton held in place snugly by a six-tailed bandage, well drawn up. The patient was under the influence of chloroform for about three hours and a half. When she came out from under the influence of the anæsthetic she felt comfortable, and was very hopeful. Her husband saw her for a few minutes about 10 P. M.

Her pulse and temperature were slightly below normal, and she was given Camph.*0*. During the night her pulse and temperature ran up (temperature 102°), and she was given Acon.[3] Under this her temperature sank, until next morning it had fallen to 96°. She

complained of some thirst. She was given cracked ice and again put on Camph.θ. Her temperature continued to fall until, at 11 A. M., it stood at 94.5°.

There was a great deal of doubt as to the correctness of this reading, so it was verified by two other thermometers.

This subnormal temperature kept up until the morning of the third day, when it rose and registered 99°. Then it sank again, and at 2 P. M. it was 97.6°, rising to 100.4° at 9 P. M. After this it sank steadily until, at 3 P. M. of the fourth day, it was 96.6°. Soon after this she went into profound collapse, and died at 5 P. M.

In the afternoon of the second day she complained of pain in the small of the back, and this gradually became very severe. With the exception of some little pain along the line of the incision and some bloating, she made no other complaint.

Post-mortem at 9 P. M.

The edges of the incision were found to have become adherent. On examining the tear in the colon a leakage was discovered in the lower angle of the wound and a small fecal extravasation and peritonitis around this. The cysts were somewhat red and injected on their inner surfaces, but no great amount of inflammation seemed to exist. The origin of the tumor was not searched for.

There was some doubt as to what was the best plan to pursue in the management of the cysts when it was found they could not be removed. The anterior cyst could have been included in the incision but to include both, owing to their large size and the thickness of the walls, was impossible.

Had the adhesions to the posterior surface of the hinder cyst been discovered before it was tapped the best plan would, very probably have been to let it alone and include the anterior one in the incision and close up the abdomen, but after it was once tapped this was out of the question.

A remarkable thing about the case was the extremely low temperature recorded two days before the patient died, and also the absence of all signs of peritonitis, except bloating.

A CASE OF UTERINE POLYPI.

BY R. P. MERCER, M. D., CHESTER.

In the month of July, 1873, I was called to attend Mrs. L., aged 38, the mother of six children. She was anæmic and debilitated, suffering from headache, backache, gastric disturbances, uterine pains and hæmorrhage. The hæmorrhage, which had been profuse, was now much less, and the pains lighter. She said she had just had or was about to have a miscarriage.

A digital examination, per vaginum, revealed the os open so that the finger could be easily passed through the cervix into the womb, which was in position and but slightly enlarged. And so far as could be ascertained, empty. There was still some pain and hæmorrhage with nausea, all of which soon stopped under treatment. The discharges had all been put away, and whether anything, or what, had been passed could not be ascertained. The history of the case revealed the fact that she had, for several months, been having quite profuse hæmorrhage, with pain, at each return of the menstrual period, which would cease after a day or two, but for the last two or three months, had not entirely stopped; it would subside into a slight but constant flow. She had evidently lost much blood, was very weak, and the stomach and digestive organs in a very irritable condition. She had, too, every appearance of being heavily drugged. She had been under *regular* old school treatment, and had taken enough of medicine, as she stated, "to last a lifetime." I doubted her diagnosis of miscarriage, but felt satisfied that whatever might have been the cause of the pain and hæmorrhage, the immediate danger was now over, and at once set about to repair the damage done.

She commenced at once to improve under the carefully selected remedies, and in a few weeks was better than she had been for months before, and in three months was quite well, better than before, she said.

She continued well, grew much stouter, round, plump and plethoric. Her menstrual periods were regular and natural. All the functions of the reproductive organs seemed normal until June, 1878, four years from the time I was first called, when the

menses began to show signs of disorder. They would appear at the proper time but the flow was much more profuse and accompanied by pressing or bearing-down pains, slight but well marked. In a week or ten days she was over it, and would remain well until the next month, when the same symptoms would again return and pass as before; examination revealed nothing except a slight enlargement of the uterus. The August period passed as the other two, but in September I found the os somewhat dilated, and after considerable effort succeeded in introducing my finger into and through the cervix when it came into contact with something just within the internal os which, although it was firm, I was strongly inclined to believe was a placenta (I had not then had my first case of placenta previa) and concluded to continue treatment and await developments.

The flow did not entirely stop during this period, but was slight and continuous. The os remained open, there was little pain and her health in other respects was good.

About the middle of October, after a more extended and careful examination, my diagnosis was a polypus with pedicle attached to the side of the uterus about an inch above the internal os, and advised its removal. Surgical aid was called and we removed, by ligature and scissors, a fibrous polypus with short pedicle, the size of a hen's egg.

She was advised that this would be the last of her trouble of this kind, and in a week or two she was well and happy, attending to her household duties, and going where she pleased.

In October, 1881, we removed another of the same character, and preceded by the same train of symptoms as before. This time the tumor had passed down into the cervix and was a third larger. The ecraseur was used and the internal surface of the womb cleared of any and all growths that might remain.

The recovery was rapid, and health remained good until the spring of 1883, when the same train of symptoms again set in.

The tumor grew rapidly and became much larger than either of the preceding, but, as the hæmorrhage was less, I concluded to wait awhile for it to mature.

One evening in the early part of June, I was sent for, the messenger stating that Mrs. L. was in much pain and wished to

see me at once. I found her in bed, having strong, labor-like pains, and the vagina filled by a mass as large as a child's head A turn or two twisted off the attachment and the tumor came away. Laying it to one side and returning my hand into the vagina to ascertain the condition of the womb, I was surprised to encounter another tumor as large as the one I had just taken away (I began to wonder what next), but soon found that it was an inverted uterus that I had to deal with now. The pedicle had been attached at the fundus and it had followed the tumor down into the vagina, causing a complete inversion of the uterus. I now had an opportunity to see the internal surface of the womb, and, bringing it down, I made a careful examination, but could find no sign of any growth or anything abnormal. It appeared to be in a healthy condition except where the pedicle had been attached, and this had the appearance of having been partly strangulated before it had come away.

Bunching my fingers against the inverted fundus and pressing gently, but firmly, upwards, I found but little difficulty in reducing the womb, it going into place after a few minutes, with my hand inside. After carefully withdrawing my hand, contractions soon set in, and the organ was gradually brought to its size and place. There was less hæmorrhage this time than before, and the only troublesome symptoms were the irritable condition of the stomach, with nausea and vomiting when anything was taken, which was soon relieved by the proper remedies, and our patient was around as before.

By September of last year (1885) she had another well-grown tumor, and by the urgent solicitation of would-be friends was induced to apply elsewhere. So my patient passed from under my care into the hands of the old school, from whence she had come almost twelve years before.

In October last Dr. ——, with the assistance of three others and two daily newspaper reporters, removed a fibroid tumor (so they named it at the time) similar in every respect to the others, but less in size than the last one.

After three months of the most approved old school medication, our patient was in a very low, exhausted and starved condition, being unable to retain food or drink or to sleep night or day.

Another operation was urged as a necessity (for what I never heard), and after much cutting, scraping and Listerizing, it was pronounced to be cancer of the womb, and in February, she died.

Such is a brief history of this case from the time it came under my care from the old school until she returned and died on their hands, covering a period of nearly twelve years, much of which time she was under treatment with the most carefully selected homœopathic remedies that I was able to find; her general health improved, it is true, but the tumors persistently returned at shorter intervals.

My object in reciting the case here is to call forth a discussion of the following points, which I acknowledge myself unable to answer, or to find answered, viz.:

First—Do uterine fibroids ever become cancerous, that is, do non-malignant growths ever become malignant?

Second—Can a cause for uterine fibroids be given?

Third—Will homœopathic medication relieve, arrest or modify them?

THE IMPORTANCE OF IMMEDIATE OPERATION FOR LACERATION OF THE PERINEUM.

BY ISAAC G. SMEDLEY, M. D., PHILADELPHIA.

The subject I wish to present to you is by no means a new one, but it is one of great importance to the poor suffering female members of society, that I wish to create among the profession a sentiment favoring an immediate operation for a lacerated perineum; instead of allowing patients either to suffer on through life, or to submit to a secondary operation, the results of which are far inferior to those of the primary.

Before proceeding with our subject, let us briefly review the construction of the perineum, and its physiological functions, so that we can more fully appreciate the importance of our paper.

About half way up the vagina, this passage and the rectum separate, the latter taking a downward and backward course, the former downward and forward in the direction of the pelvic curve. Thus an irregular triangle is created, of which the external perin-

eum is the lever—the posterior vaginal wall and the anterior rectal wall forming the sides. This triangular space, occupied by muscles and their tendinous attachments, vessels and nerves, is the perineal body.

Dissecting off the skin and superficial fascia, we come, midway between the anus and posterior commissure of the vulva, to a highly elastic and dense white tendinous structure, which seems to be made by the fusion of several muscles meeting at this point.

The external sphincter ani, which arises from the os coccyx, surrounds the anus, and is inserted into the perineal body.

Starting at the perineal centre, we find two muscles, some of whose fibres become continuous with the external sphincter, and which pass forward, separate, and pass around the vulvar opening like a fleshy ring, and then converge, each to meet its fellow from the opposite side over the clitoris. These form the constrictor vaginæ muscles—called also the compressor bulbi, and the bulbo-cavernous muscle. The transverse perinei muscles arise from the ascending rami of the ischium, and become united with each other in the perineal body, and also with the sphincter vaginæ, and levator ani muscles. The levator ani muscles, are next in the group in power and importance. They arise from the rami of the pubes, from the spine of the ischium, and from the tendinous bands stretching between these points, and are inserted into the coccyx and the perineal body, and they also interlace with the corresponding muscles of the opposite side; thus constituting the true sphincter of the vagina.

The bulbs of the vestibule and the vulvo-vaginal glands, lie in contact with the constrictor vaginæ muscle, on its under side. By a contraction of these muscles during coition, the flow of blood is impeded, causing a congestion of the erectile organs. The contents of the vulvo-vaginal glands are squeezed out and the clitoris is drawn down upon the male organ.

We see, therefore, that the floor of the female pelvis, is composed of a mass of muscles so interlaced that scarcely one of them has a special property which is not, in a measure, shared by the others. Hence, a loss of any fibre at the point of fusion, entails a corresponding loss of power in the floor of the pelvis, and a consequent impairment to the support of the reproductive organs.

The perineal body fits like a wedge between the rectum and the vagina, thus supporting the anterior wall of the rectum and sustaining the equilibrium of the rectum, vagina, cervix, and the body of the uterus. It also supports the posterior wall of the vagina; upon the posterior wall rests the anterior, upon that the bladder, and against the bladder the uterus, all of which depend largely, for support, upon the perineal body.

Another important function of this body is to preserve the proper line of projection of the rectal and vesical contents, thus preventing the occurrence of tenesmus which is a frequent cause of pelvic displacements.

The causes of laceration of the perineum, and its preventive treatment, belong more properly to the obstetrical bureau, and hence will not be discussed in this paper.

The different varieties of this accident are all so familiar, that it would be useless to mention them here, but there is one form upon which I should like to dwell, and that is what we might call an intra-vaginal tear. This is a tear of the perineal body down to the sphincter ani muscles leaving the external or skin perineum intact. I wish particularly to call attention to this variety of laceration from the fact that it is so liable to be overlooked, and at the same time, neglect of it is attended by results quite as serious as from any of the incomplete varieties. From an external inspection, a tear of this kind could not be discovered, therefore, when examining for laceration, this variety should be borne especially in mind. It becomes an imperative duty always to examine patients, after confinement, for any perineal tear. Perhaps an experienced finger can detect this without the use of the sense of sight, but I always expose the parts to a good light, and carefully wipe them with a cloth, before I can feel satisfied of their exact condition.

The amount of danger resulting from neglect of the laceration will depend upon the degree of the tear. The more extensive the tear, the more severe will be the symptoms, and the sooner will they develop, but sooner or later, in any case, they must develop from a neglected laceration.

The immediate danger is from blood poisoning. This raw surface, with its enlarged and open vessels, over which the discharges

from the uterus are obliged to flow, offers an excellent opportunity for the absorption of the diseased germs, which such discharges are apt to contain.

The remote dangers are: rectocele, cystocele, prolapsus and congestion of the uterus, and procidentia, arising from an incomplete tear; and from a complete tear, the foregoing together with rectal and vesical incontinence.

The final result from the primary operation is far better than from the secondary, although from the latter we may have a union equally as good as that obtained from the former. If a muscle in any other part of the body should be torn across a rational surgeon would immediately set to work to bring the ends of the muscles together in proper apposition, with a hope of getting a primary union; for if the wound is allowed to granulate with the ends of the muscle separated, the result would be a useless organ. Just so, I claim, it is with these perineal muscles. When once allowed to heal without proper attention the organ is forever impaired. You must not understand me to say that I do not believe in the secondary operation—far from it. It is the best that can be done under the circumstances, and I know of no operation that will give a patient so much relief as the restoration of this support. For we can apparently restore it—making what is, to all appearances, as nice and firm a perineal body as nature had originally given, but the parts can never be so firm and resisting as though the muscular fibres had been properly united, and if the uterus is enlarged, or there has been a marked cystocele, the constant pressure on this new body will cause them to become absorbed, and the parts will be almost as useless as before.

There are a few cases where the primary operation is contraindicated; for example, in cases of convulsions, excessive uterine hæmorrhage, excessive exhaustion, advanced organic disorder, mania, etc., etc.

THE OPERATION.

Very frequently the parts are so benumbed by pressure that it causes very little pain to introduce the sutures. If it is attended by much pain, it is best to etherize the patient in order to prevent fright, shock and muscular contraction.

Sponge out the vagina and raw surface carefully with iodine and

water, or some other disinfectant, and pack the vagina with two other sponges to prevent the flow of blood upon the raw surface. Control all bleeding vessels by torsion, and the oozing by hot water, and clip off all ragged and irregular edges.

There are many methods for uniting the torn surfaces. but that devised by Simon, of Heidelberg, has been, for me, by far the most successful, except that I substitute cat-gut for the silk which he recommended.

The operation is simply this: A line of interrupted cat-gut sutures is inserted, beginning at the upper angle of the tear, *i. e.*, that part which extends farthest up the vagina, the stitches being just close enough to bring the parts nicely together. This is continued until the external perinæum is reached, after which the skin perinæum should be united in the same way.

In case of a complete tear, the vaginal part should be united down to a level with the rectal rent. Alternate stitches should then be taken in the rectum and vagina until the outer extremity is reached, when the operation is completed as in the former case.

The advantage of cat-gut over silk is that it is difficult to remove the silk from the vagina, while, where cat-gut is used, it may be allowed to remain in the tissue until it is absorbed. I think this method far superior to the wire sutures, for it brings the parts nicely into apposition, without leaving a puckered, gaping edge in the vagina, which allows the discharges to trickle down into the wound, often preventing union. This I have frequently seen occur both in my own operation, and in the hands of skilled gynæcologists, but since using Simon's method I have never had but one failure, and that was in a case where I operated twelve hours after the accident occurred. This was done at the urgent request of the attending physician, but much against my own judgment, for I consider it useless to attempt to get union after a lapse of eight hours.

MECHANICAL VERSUS MEDICINAL MEASURES IN UTERINE DISPLACEMENTS.

BY EMMA T. SCHREINER, M. D., PHILADELPHIA.

It is not necessary to enter into any argument for or against the use of purely manual or instrumental means of correcting uterine

displacements. Such discussions are always one-sided, and only serve to add to the "bone of contention" interposed between the surgeon and physician. Too many of these discussions have been published, to the bewilderment of the student and young practitioner, whose oft-repeated question, "What is truth?" fails of satisfactory answer. Is there not some common ground, where men and women of common sense, the specialist, surgeon, and the advocate of only the similimum for "all sorts and conditions" of the human frame, can meet? It would seem that there ought to be. Before prescribing for a mal-position or a mal-location of the uterus, besides taking into account all the symptoms present, it seems necessary to ascertain, if possible, the primary cause of the trouble, it may date years back, and be obscure and difficult to find, but once found, it may prevent much waste of time in bringing about a cure. If the displacement has been caused by violence of any kind, if the chief factor in the displacement has been mechanical, then mechanical measures must enter largely into the curative treatment.

Cases naturally divide into three classes:

I.—The first, requiring chiefly mechanical treatment, is usually made up of acute cases. Patients of this class are most often those in good health otherwise, often robust, active, accustomed to vigorous exercise or hard work. Such persons are liable to over-exert themselves, and by some sudden strain or violent action, a displacement of the uterus is brought about. A jump from a height, a fall down stairs, or being thrown while riding, has caused a displacement which requires manual reduction, quite as much as does any external dislocation, and here medicine is simply an adjuvant.

Case I.—A girl of seventeen years came to me with severe pain in hypogastrium, back, and groins, nausea and indigestion. Her troubles followed a jump from a fence with a heavy child in her arms. This occurred one week before she came under treatment. The correction of a retroversion and one prescription of Arnica[30] effected an almost immediate cure. Sometimes a trouble of this kind causes an entirely different train of symptoms, as in the following.

Case II.—Miss A., æt 20 years, suddenly began to suffer from

extreme depression of spirits, which continued one month, when it amounten to true melancholia. Her mental suffering was terrible to witness. Instead of being the sunny, helpful, sweet-tempered girl of six weeks before, she was morose, gloomy, reserved, seeking solitude, ever mournful, wishing to die. One day when left alone a few minutes, she opened a vein and had lost much blood before being discovered. In health, the most conscientious of beings, she now felt no responsibility for such an act, and only regretted its non-consummation. She had sleepless nights, ate only because of her friends' entreaties, and was beginning to lose her strength. Her previous health had been superb, and even during this attack she was induced to exercise daily, boating, riding, walking, etc. Her menses not appearing at the second month, an internal examination was insisted upon, when there was discovered a left lateral flexion of the uterine cervix. The cervix was bent over like a knuckle, the os much compressed and presenting a narrow line from front to back. The fundus was readily pushed up and kept in place by a tampon of cotton, inserted upon the left side. The patient was directed to lie upon the right side, at night, and several times during the day.

In less than six hours, the cloud seemed to roll off of her mind, and from that time on she was radiantly happy. She seemed to herself, as well as to her family, restored to life. After recovery, she said, in answer to questions, that at the beginning of her misery she did have pain, burning and dragging in the left side ; but they went unheeded, because the mental anguish was so overpowering. A sudden wrench received in a gymnasium is considered the cause of the displacement. One week after its reduction she was perfectly well and happy.

II. The second class comprises that great company of suffering women, whose muscular tissues are so undeveloped, or weakened, by artificial restriction, that they form an insufficient protection for internal organs, which, in consequence, perform their functions imperfectly, and become easily deranged. Such slight causes as teaching an organ, lifting a not very heavy weight, reaching to a height, playing lawn tennis, or the pressure of stiff stays and heavy clothing (with or without violent exercise), induce displacements, to which reduction and internal mechanism afford only tem-

porary relief. To effect a sure cure, we need a combination of forces: First, modify the dress to secure perfect freedom of action for all parts of the body. Lightness is important, and if the chest organs are stronger than the pelvic, let all the clothing be suspended from the shoulders. This done, and the displacement corrected early, we may hope that the indicated remedy, with strict attention to diet, exercise, etc., will insure a cure.

Case III.—Carrie W., æt. 23 years, for three years suffered from pain and distress of a somewhat varied character, attributed by different physicians to malaria, disease of kidneys, and various other causes. She had been an unusually strong and active girl, doing and enjoying field work usually considered too heavy for women. A year previous to her sickness she had left her salubrious home and taken service as child's nurse in a very malarial district. Her general health suffered from the change; she had not her usual strength yet, being accustomed to heavy lifting and carrying, tried to continue these feats in her new position. Her sickness was not acute at first, but increased gradually. For three years, she had been under old school treatment, and was constantly growing worse.

Examination showed a prolapse and retroflexion of the uterus, which could be only slightly moved, owing to adhesions and thickening of surrounding tissues from chronic perimetritis. This condition was doubtless secondary to a mechanical dislocation. The patient was much reduced in flesh and suffered from frequent and violent attacks of indigestion.

The hot vaginal douche did good service in this case. The patient was sure it would do her no good, as she had used it before without benefit. Inquiry elicited the fact that it had been taken in a sitting posture. Given, twice daily, with the patient upon her back and the hips elevated, it proved very beneficial. (To provide for the waste water flowing off, the patient was placed, with hips elevated, on the edge of a bed, her feet upon two chairs, between the chairs a bucket, and the rubber sheet covering a pillow under the hips, formed a trough leading into the bucket. In the absence of the siphon bed-pan, this substitute will answer well.)

Water at a temperature of 100° Fahr. was complained of at

first, so the douche was begun at blood-heat, and gradually raised to 115°. When the douche was discontinued and the patient first allowed to be upon her feet, she almost demanded a supporter of some kind. The request was not complied with; instead, massage was given, and a regular routine of exercise and rest, with all due attention to dress, etc., insisted upon. The indicated remedy was given at all times, and in one year from coming under treatment, she was so far recovered as to be able to comfortably earn her living.

III. In the third class, are placed those women whose uterine derangements are the result of local disease, inflammatory or otherwise, or of a generally debilitated condition. They may have stood in stores, or have been in constant attendance upon the sick, or have become utterly relaxed from some long illness of their own. The uterus is displaced, sometimes in one direction, sometimes in another. No local treatment is necessary for these last. The positional treatment, by the use of the Moor chair, is a great comfort and aid to relaxed tissues. Very helpful positions may be assumed without this chair, but with it the patient feels that more is being done, and is less anxious for local treatment. Remedies, homœopathically indicated, are here our sheet anchor, as also in all tumors and locally diseased conditions not due to immediate external causes. In the tissue changes following inflammatory affections, local treatment is an important adjuvant, but I believe the conditions requiring it are usually the result of some external influence. The indications for many of the operations in vogue may also be determined by the cause of the condition. When prolapse of vaginal walls and adjacent organs has been caused by difficult labor and premature "getting up," the patient being healthy, the best results from operation may be anticipated. But in very much the same condition, when the cause is *disease*, or *general debility*, better results may be secured by the same period of enforced rest and medical attention which the operation would necessitate, without any surgical interference whatever.

Case IV.—Mrs. L. (widow), æt. 41, had always been delicate; was of a highly intellectual and emotional nature; had nursed her husband and her father in tedious illnesses, terminating with death; was constantly anxious about her own and her children's health.

The patient came to me for "falling of the womb." Examination revealed a very roomy pelvis, with an utterly lax condition of all the soft parts. She had worn various supporters, each one of which had caused leucorrhœa and pain. The uterus changed its place with every change in the patient's position, and she refused to stand erect without a cotton tampon or support of some kind.

Treatment was directed toward energizing and toning up her system, and her first walk without a supporter was taken while under the impression that she was still wearing one. This walk was so much enjoyed that no further trouble ensued from pessaries. Much comfort and actual benefit was derived from the use of Dr. Moor's chair, and from abdominal respiration, regularly practiced in loose clothing, which allowed the retentive power of the abdomen to be fully exercised. This patient will always be delicate; she probably would not be happy otherwise; but her attention is not drawn to her uterus any more than to other organs, and she is not injuring herself with pessaries. The homœopathic remedy always gives her sufferings prompt relief, and she enjoys life well.

TREATMENT OF STERILITY.

BY HARRIET JUDD SARTAIN, M. D., PHILADELPHIA.

The subject of sterility is one that should command the attention of the general practitioner, as well as of the gynæcologist. Although quite uncommon among the ancients, it is now stated by Sims and other authorities, as summed up by Edwin M. Hale, M. D., in his work on sterility, that about every eighth marriage is sterile. This is not only in our own country, but in foreign countries also. Whether or not this increase is due to a more luxurious mode of living than in the past, including highly seasoned foods and stimulating drinks, over heated rooms and lack of out door exercise, the fact still remains.

One might judge from the children that fill the courts and alleys, among the hard worked, poorly clad and ill fed part of our population, that such might be the case, but it is of the higher classes

where people desire children and do not have them, and where their advent would be hailed with delight, and the world would be better for their being born, that I propose to speak.

Simple stenosis of the os uteri and os internum, without disease, is very frequently met with. Dilatation is its cure, but dilatation in careless hands often produces bad results. Not wishing to injure the cervical tissues, I do not dilate under ether, but let the patient govern the amount, by what she can bear without *severe pain*, preferring gradual dilatation to the rapid and forcible method now so much the fashion. In simple cases, I use T. G. Thomas' dilator, with which you are all familiar; in those more serious, Molesworth's; beginning one week after the menses cease and repeating twice a week, making four times before the return of the period. In many cases it is all that is necessary. If the menses return after the second period, I again repeat the treatment.

A lady in perfect health, who had been married many years without children, consulted me as to the reason. I could discover nothing, but remarked the os might be a little larger and it will do no harm to dilate it, and did so. It was the day before the period, but the menses did not appear, and the one dilatation was followed by conception.

Stenosis with cervicitis requires the same process of dilatation with local applications. For simple inflammation, an application of carbolic acid one part and glycerine ten parts, is stimulating and cleansing, and serves a good purpose. If there is erosion or laceration, fluid ext. hamamelis or hydrastis canadensis, or if an old and deep-seated ulceration, sulphate of copper or boracic acid, with appropriate internal remedies. Those I have found most efficacious, are; Actea, Apis, Bell., Kreosotum, Lachesis, Merc., and Sepia. Endometritis should be treated by dilatation and the same local applications as cervicitis, applied by wrapping a mop of absorbent cotton around the end of the forceps and clasping it, so as not to lose it within the cavity.

If a bland, thick leucorrhœa issues from the os, with pain in the back and head, and great depression of spirits, Actea. If the discharge is acrid, and irritating to the mucous surfaces, Kreosote. Discharge profuse, greenish-yellow and offensive, Merc. viv. If the uterus is enlarged and indurated, a speedy reduction can be

brought about by a pledget of cotton saturated with carbolic acid and glycerine, once in three or four days ; if exhausting to the patient use hydrastis and glycerine instead, with Actea three times a day. After the removal of the cotton, which should be retained about twenty-four hours, or as long as the watery discharge it causes, continues, an enema of one part milk and two of water, daily, until the next treatment. is very soothing and healing. Cosmoline, applied by the patient herself, is sometimes preferred. Vaginitis requires the same local applications and the internal remedies that are indicated by the character of the discharge. Ovaritis should be treated by the indicated remedies. While our text books give Apis for the right ovary, I have found it more useful for the left. I have often cured an irritation of the left ovary of long standing, with Apis alone. I change the potency instead of the remedy in affections of the left ovary, until fully satisfied Apis will not do the work. Next in value for the left is Lachesis. For the right, Belladonna and Apis ; and for either if indurated with constant burning pain, Ars. iodatum. The potencies I prefer are the 3d, 30th and 200th.

Sterility depending on congestion induced by different measures for preventing conception is most difficult to cure. The vitality of the tissues is so impaired that any slight abrasion soon becomes a deep ulceration, with a muco-purulent discharge. The general system is very much affected, also the nervous. Pain in the top of the head and down the spine, particularly in the sacral region, and depression of spirits usually attend such cases.

The semi-weekly application of cotton saturated with carbolic acid and glycerine, and Actea[3], three times a day, for some weeks, combined with proper hygienic measures, will slowly bring about a radical change, and with a good constitution sometimes a cure. Sterility may be is brought about by criminal abortion frequently repeated, and although the patient seems to recover her tone, she remains sterile, while abortions due to other causes, are curable and followed by offspring. Women often are childless and the subjects of repeated abortion from specific disease in the husband.

In failing to cure such cases our skill is often questioned, but it is to the credit of the profession that its members keep silent,

when speaking would destroy the happiness of their patients. It may seem a happiness built on a poor foundation, but if under the circumstances it is the best attainable, it should be saved when possible. Sterility is sometimes due to polypi, either fibrous or vascular, that act as mechanical obstructions. The treatment is their removal, accompanied by such remedies as Calcarea carb., Staphsagria, Teucrium and Sulphur.

Cervical laceration sufficient to cause sterility requires a surgical operation. That I need not describe as you are all familiar with it, and if not, it is fully laid down in our text books.

For sterility depending on mal-positions, repositing the organ and supporting with sponge or cotton and internal remedies as indicated. Lilium, Nux vom. and Sepia. For flexions, similar treatment combined with dilatation. Imperfect development of the uterus is often met with. I have examined cases in well developed women above the ordinary size, where the uterine cavity would not measure over one and a half inches, and the os and cervix would only allow the passage of the smallest French bougie, and that after several attempts.

Repeated dilatation has been followed by conception, and full grown children have been born at term without injury to the mother. In one case so treated, a well developed child died shortly after birth, and the mother two hours later, apparently from exhaustion; as the attending physician told me he could find no other cause for her death. She was perfectly well during her pregnancy, which terminated in a natural labor.

I know it is considered necessary, by some authors, to try to develop the uterus by electricity, tents of different kinds, and remedies before conception, but in my experience, pregnancy has proved the best and safest developer.

Vaginal atresia, congenital or acquired, needs a surgical operation. A case following severe inflammation and severer caustic treatment, on which I operated, was followed in less than a year by the birth of a healthy child at full term.

Sterility following peritonitis or pelvic cellulitis after labor, is cured by the treatment and remedies that cure ordinary inflammation, congestion and induration. I have spoken of cases that are amenable to treatment, and have avoided such as are absolutely

sterile, from absence of the uterus or ovaries or both, or diseases that destroy the vitality of the tissues, as in such cases all interference is useless.

DYSMENORRHŒA.

BY THE BŒNNINGHAUSEN CLUB, PHILADELPHIA.

Dysmenorrhœa and Its Causes.

Dysmenorrhœa, as the name implies, means painful and difficult menstruation. A disease which is apparently much on the increase, due, no doubt, to very many causes. This disease has been referred to five different conditions, hence we will have to recognize five different kinds of dysmenorrhœa, namely:

First; Mechanical or obstructive dysmenorrhœa;
Second; Congestive or inflammatory;
Third; Neuralgic, sympathetic or spasmodic;
Fourth; Membranous;
Fifth; Ovarian Dysmenorrhœa.

The first-named, mechanical or obstructive, form is no doubt the most common of any of the above-named forms. It is claimed by some physicians that dysmenorrhœa cannot exist without some mechanical or obstructive means to the flow of the menstrual fluid from the uterus. There are various opinions as to this claim, as well as to where the seat of the obstruction is generally located. There is but little doubt but what it is usually situated in the uterus, but it may be and sometimes is in the vagina. Some writers think it to be generally in the os tincæ, either the external or internal; in either of these cases the physician is apt to find a conical cervix. A false membrane sometimes grows in the cervical canal and causes an obstruction; clots of blood or viscid mucus may cause an actual obstruction. Uterine polypi and fibroid or other tumors may cause obstruction to the flow, and hence very severe cases of dysmenorrhœa.

Flexions form an important part in many cases, perhaps in the majority of cases. Flexions, to cause dysmenorrhœa, must be quite acute, for the obstruction in such cases is caused by the cer-

vix uteri being flattened, bringing the walls so closely together as to retard or stop the flow of the menstrual fluid.

That the external os of the uterus is occasionally so small as to cause an obstruction cannot be doubted, for it has been proved beyond a doubt. This cause may be congenital or secondary. It is often the result of application, to the membrane of the cervix, with nitrate of silver, or some other powerful caustic; but we have no records to show that there are a great many cases, where the obstruction is at the external os, and still less cases are reported where the obstruction has been found to be at the internal os of the uterus.

Retroflexion is, no doubt, the most common and severe, as the angle of flexion is much more severe than in any of the other recognized forms of flexion. Although a pin-hole channel through the cervix uteri has been known to permit of a fatal hæmorrhage, we are led to infer from this that if the menstrual fluid is in a perfectly normal condition, that it will pass through a very narrow channel without causing dysmenorrhœa. There are several reasons for believing that the obstruction is not always in the genital passage for the menstrual fluid, for instead of the homogeneous nature of the menstrual discharge, blood, mucus and the molecularly disintegrated decidua, there are often clots of blood, masses of viscid mucus, fragments of the inner surface of the uterus, etc., which clog up or obstruct the menstrual flow, and give rise to severe cases of dysmenorrhœa. This obstruction, or common form of dysmenorrhœa, is often accompanied by inflammation or congestion of the body of the uterus, as well as an inflammation and abrasion of the lining membrane of the cervix; that these complications contribute to the cause of pain with the obstruction present cannot be doubted. It should be borne in mind that not all cases of dysmenorrhœa are constitutional, but that there are many incidental causes which might be mentioned, such as arise from wearing tight-laced corsets, high-heeled shoes, over-fatigue from long walks, standing for hours upon stone floors without resting the uterine ligaments, dancing, jumping from high objects upon the floor or hard ground, lifting and carrying heavy burdens, catching cold at the menstrual epoch, shocks to the nervous system, whether it be from fear, grief or joy, or remaining in the water too long when bathing, not

unfrequent after the new relations incident to marriage. Inflammations and ulcerations; ulcerations in the virgin state, may be a cause. Ulceration, following inflammation of the cervix, is quite a common cause of dysmenorrhœa.

This mechanical or obstructive dysmenorrhœa is apt to afflict old maids more than married ladies. In fact, a cure usually follows childbirth.

The symptoms of this form of dysmenorrhœa are various and differ in intensity, being mild in some cases and very severe in others. The pains usually commence in the pelvis and radiate to the groins, sacrum and thighs. The hypogastrium and groins are usually very sensitive and tender; in many cases the whole trunk seems to share the aches and pains. The pains may make their appearance a little before, with or soon after the appearance of the menstrual discharge, and they may cease with or soon after the same, or they may continue, more or less severe, during the whole menstrual epoch. With the paroxysmal pains we may find vomiting, headache, hysteria, delirium, and even convulsions.

The menstrual flow may be scanty or profuse; in either case, it is apt to be followed by a yellowish discharge for several days after the flow stops, this to be followed by a leucorrhœal discharge throughout the entire inter-menstrual interval.

Second—*Congestive or inflammatory dysmenorrhœa* is the name given to those cases where the uterus is congested or inflamed, causing it to be much heavier than natural. This form is found more in the married than in the single; in fact, it is quite rare to find a case of inflammation of an unimpregnated uterus, and when such is the case, it is usually caused by the obstruction which has been at work for months, and perhaps years, before the inflammation began. It is found particularly in women of full habit and sanguine temperament; young girls with florid complexion and plethoric habits, before the menstruation is fully established. It may be caused by exposure to wet or cold, may be in consequence of exciting or depressing mental emotions. Displacements of uterus, sub-involution of uterus, following labor, may cause it; in fact, anything that tends to keep an hyperæmia in the uterine vessels, and cause pressure on the neighboring tissues, will cause con-

gestive or inflammatory dysmenorrhœa. The symptoms of this form are similar to those of mechanical or obstructive dysmenorrhœa.

Third—*Neuralgic, Sympathetic or Spasmodic Dysmenorrhœa.* This form is less common than either of the former mentioned varieties, yet at one time it embraced many cases which came under notice, but since more efficient means have been employed for learning the condition of the uterus, the number in the category of cases has greatly diminished. At present it is limited to cases in young girls, to whom it is not desirable to make a vaginal examination, and to those cases where no pelvic lesion can be found to account for the suffering. Some physicians say there can be no neuralgia of the uterus, but that cannot be very well doubted, yet cases of this kind are rare, and it takes no little care to correctly diagnose a case of this kind. This form of dysmenorrhœa may be said to show itself more in ladies of a neuralgic or rheumatic diathesis, and who are subject to neuralgic pains in other parts and organs of the body. It may be due to plethora, or the opposite condition—chlorosis; gouty patients are apt to have it. It may be caused by excessive sexual intercourse, or by masturbation. The pains are spasmodic in their nature, and often of the most distressing character, lasting for hours, and sometimes for days. They simulate the pains of labor, and they are equally if not more agonizing, the pains being more steady. In fact, sometimes they are continuous, running to the small of the back, down the lower limbs, into the sacrum and hips, into the iliac and hypogastric regions, with frequent inclinations to urinate from the sensation of weight, fullness, and bearing down feeling in vulva, perineum, rectum and coccyx. Usually, after the menstrual flow is established, the pains and spasms moderate or cease altogether. This form of dysmenorrhæa is, taken altogether, a very severe and distressing condition for a patient to get in, and one which taxes the physician's skill to cure.

Fourth. *Membranous Dysmenorrhœa.*—This is the name applied to cases where there is a distinct membranous cast thrown off at the menstrual epoch (which, if not carefully noticed, might be taken for the product of conception). In these cases, the mucous lining of the uterus seems to be much thicker in structure than natural,

but this cast is identical in structure with the lining of the body of the uterus, it contains glands, blood vessels, and is in fact the decidua; when it is thrown off it does not, under ordinary circumstances, break down into impalpable shreds. It may come away whole or in parts, when it is expelled whole the pains and spasms are severe, almost like labor pains. The pathology of this distressing form of dysmenorrhœa is not understood.

Fifth and last. *Ovarian Dysmenorrhœa.*—This last form we have to consider barely deserves the name of dysmenorrhœa, for it is not due to menstruation; that is to the discharge of the sanguineous fluid from the uterus, but to the growth and rupture of the Graafian follicles of the stroma or surface of the ovary and the extension of inflammation to the surrounding tissues. It is mostly always of a secondary nature, rarely if ever primary, found mostly in ladies who have had children, and is often the consequence of an abortion. In the unmarried, it is quite rare; when found in the unmarried it is due to violence, or to true dysmenorrhœa primarily, and ovaritis secondarily; exposure to wet and cold about the time of the menstrual flow, severe injuries on the abdomen, over the ovaries may be causes. The pains are different from the other forms of dysmenorrhœa I have mentioned. It is by no means a sudden process as the Graafian follicle usually ripens and ruptures several days before it is thrown off in the menstrual discharge, and sometimes it is thrown off after the flow ceases, perhaps several days after. The pains generally come on several days before the catæmia and may cease with the appearance of the menses, or they may cease several days before that event. The suffering may begin with the flow or during the interval. It is usually situated in the left ovarian region, as the left ovary is the one most apt to be affected, due, perhaps, to the irritation caused by constipation, etc., in the descending colon; the pains extend down the hips and thighs into the sacro-iliac joint of the affected side, with a tender kidney on that side. Patients will often complain of swelling on the affected side, and upon examining the side a diffused fullness is found in the ovarian region which is usually tympanitic, and due, evidently, to local distention of the intestine by gas. Examination per vaginum or per rectum will often detect a small tumor, tender, movable in the early period of the disease; later on more firm; it

is usually a little behind the uterus. Pressure on this tumor produces severe pain and sickness. Later on, the uterus becomes less movable and drawn to the affected side, due to contraction of inflammatory products, and not to distension of the broad ligaments, for it occurs in cases of long standing. In these cases, the bladder usually becomes very irritable, causing frequent micturition, which is often very painful.

Jos. Hancock, M. D.

TREATMENT OF DYSMENORRHŒA.

Although dysmenorrhœa is only a symptom, it is such a painful one that it compels special attention to means for alleviation and cure.

While most cases respond to the well selected remedy, others yield only to operative measures; or the patient though assured of final relief from her pains, becomes impatient and wishes some more speedy way out of her troubles.

In the treatment of this painful condition, too many are apt to rely, almost entirely, upon subjective symptoms rather than objective ones, while there is no ill of female life which requires more thorough investigation as to its cause.

Obstructive dysmenorrhœa may be due to polypi which must be removed, flexions which need to be corrected, displacements which require replacing, stenosis of the cervix, which must be made round, pin hole to be enlarged, which may yield to such operative procedures as may be necessary to overcome the mechanical obstruction.

It is strongly urged in cases where time is of small moment, to dilate the cervix, by the continued use of tents, either sponge, tupelo, or laminaria, gradually increasing the size until sufficient has been obtained. Others recommend the use of graduated uterine bougies.

Goodell, of this city, speaks most highly of rapid dilatation, under ether, and recounts three hundred and twenty-four cases treated with the most favorable results. Molesworth's dilator may be used to advantage, when the amount of dilatation is not great.

If the dysmennorrhœa is due to elongated cervix, or narrowing

of the cervical canal, dilatation by one of the methods named, slowly with tents, though this has possible danger from septicæmina, or more rapidly by bougies, or Molesworth's dilator, or still more rapidly and at one sitting, under an anæsthetic, by the use of a strong steel dilator, stretching the uterine canal, from one half to one inch. There is very little danger from tearing the cervix, though there are a few cases on record. The relief obtained, in a large majority of cases, is most marked.

Septic influences may be avoided, or much lessened, by the use of proper antiseptics, carbolic acid., corrosive sublimate, Merc. bin. iod., etc. the vagina being thoroughly washed out before the operation, either with a soft sponge or prepared cotton, dipped in the antiseptic solution.

Too great care, on the part of the operator in regard to personal cleanliness, cannot be taken. The hands should be well washed with warm water and soap, using a nail brush to cleanse the nails. Many an obscure case of sepsis, both in gynæocological and obstetrical practice, may be traced to lack of care on the part of the medical attendant.

Dysmenorrhœa dependent upon a depressed state of the nervous system requires rest, proper medicine, and change of air.

The congestive variety may be treated by exhibiting the indicated remedy, the use of hot fomentations to the abdomen, sitz baths, quiet, and rest in bed.

Ovarian dysmenorrhœa is best treated by the remedy homœopathically indicated. Membranous dysmenorrhœa yields to the wisely selected remedy.

Too much cannot be urged against the use of opiates to lull the pain, for while the patient is easier, the results are most pernicious.

George T. Parke, M. D.

THE APPLICATION OF THE PRINCIPLES OF HOMŒOPATHY TO ABDOMINAL SURGERY.

BY B. F. BETTS, M. D., PHILADELPHIA.

Whilst the application of the principles of Listerism to abdominal surgery has made it possible to accomplish marvelous results, surgeons are not entirely satisfied, and are striving after improved

methods of treatment, in order to protect their patients still more effectually, from the dangers which supervene upon abdominal section. Some of the most successful have discarded the use of germicidal agents, and rely exclusively upon cleanliness as the best safeguard against infection during an operation, and as but little reliance can be placed in the efficacy of opium, quinine or digitalis to combat inflammation, but little medicine is used, either in the preparatory or after treatment of these cases. I have never felt that we were inconsistent or debarred by our faith in homœopathy, from applying the best known principles and practices of surgery, as common property, to strictly operative cases, which are not amenable to medical treatment, yet I rejoice to see that the path which such earnest seekers after truth as Tait, Keith and Bantock have pointed out, enables us to reach a position from which it is possible to apply the principles of our school to abdominal surgery. The attempt to overcome the effects of uncleanliness by the use of a strong germaciticide has always appeared to me like giving a powerful medicine to an unfortunate individual in order to keep him from getting sick. The system already impressed by the disease influence, is unable to cope with the additional burden, when it might have been otherwise victorious in the struggle. Yet I have formerly used and still employ antiseptic solutions, when I cannot secure perfect cleanliness; but what I desire is, that we should strive after cleanliness without the necessity for the employment of germicidal solutions within the peritoneal cavity. We can do this better in private hospitals, located and fitted up with proper regard to the sanitary requirements necessary for such cases, than in large public hospitals, contaminated by a vitiated atmosphere.

The toxic effect of germicidal solutions must weigh against the recovery of the patient, and more so in some cases than in others; and in estimating the amount or strength of the solution that is required in a particular case, to act as a germ destroyer, the susceptibility or idiosyncracy of the patient is not and cannot be taken into account.

This peculiar susceptibility of some patients is strikingly illustrated in the cases of corrosive sublimate poisoning that have been recently reported. Over thirty fatal results from its employment have been published, and it is likely that they represent but a

small proportion of the number that have been seriously effected but not published.

Nine deaths have occurred from the use of the solution injected into the vagina or uterus, and one fatal result followed the employment of a *weak* solution as an injection into the vaginal passage. How much more fatal must the results be, should the solution be strong enough to be of use as an antiseptic or a germicidal agent be, unwisely used within the peritoneal cavity during laparotomies.

The carbolic acid solutions are known to interfere with the eliminative action of the kidneys in some cases, and thus endanger recovery, as it is upon a proper action of the emunctories that we must place our main dependence after an abdominal section.

If I have a tumor to remove, the time to operate is not fixed by the size of the mass nor by the amount of inconvenience it causes the patient, as much as it is by the answer I can give to the question: Is it likely that there will be a time when the action of the patient's skin, kidneys and intestinal tract will be more satisfactory than at present? The probable result is estimated with far greater accuracy by a knowledge of the general condition of the patient than by the size and condition of the tumor.

With Sulp., Lyc., Nux vom., Bell., Sepia, etc., we are often able to improve this condition, especially if attention is paid to diet, bathing, inunction, etc., until the skin becomes pliable, the urine clearer and the bowels more healthy in their action.

It is considered good practice to proceed with an operation for the extraction of a tumor, whenever it is involved by serious inflammation, for inasmuch as the tumor requires removal at any rate, and peritonitis is as likely to subside after an antiseptic operation as without it, delay only permits of the formation of new inflammatory adhesions, to complicate future efforts at extraction, when the patient's life must be again jeopardized. Yet there are times when we cannot proceed with the operation, and do it satisfactorily, at such short notice.

Mrs. R. W. P. applied for treatment in July last. She was extremely weak in consequence of loss of rest and profuse menses, and suffered from such marked cerebral anæmia as to cause her to appear confused from the slightest excitement, and she was unable

to understand what was said to her or what she read at times: with ringing noises in the head, etc. I diagnosed a cystic tumor the size of a fist to the right of the uterus, but not closely attached to it. In consequence of over-exertion, within a few days, acute inflammatory symptoms, with a temperature ranging from 103° to 105°, supervened. Her sufferings were intense. The weather was very warm, but as her surroundings were favorable, an immediate operation was proposed. In a short time, the extreme pain and acute symptoms were subdued by means of Bell.[30], and delay was asked for by her friends until the patient's anæmic condition should improve and arrangements be made for her care and treatment. Since then the anæmia has disappeared under the influence of China, and she is feeling better than she has been for a long time; but of course the tumor remains the same, and to be operated on soon. With strict attention to the minutest details in cleanliness, almost any organ of the body may be fearlessly attacked, not excepting the liver, or even the brain, for the system will accommodate itself to severe mutilation without serious inconvenience or delay. The instruments used need not be numerous, and the selection of those that are simple and uncomplicated in their construction is desirable.

Silk-worm gut, immersed in carbolic acid and then washed off in pure dilute alcohol, and kept immersed in the latter fluid until used, along with the needles, answers a good purpose for closing the abdominal incision, after laparotomy. Likewise, the ligatures for the pedicle should be kept immersed in pure water or alcohol until used. Sponges can be cleaned in pure boiled water, for both carbolic and sublimate solutions deprive the peritoneal layer of some of its epithelial covering, hence conduce to the formation of those adhesions between opposite and contiguous surfaces, which lead to fatal results in some cases.

In the following case carbolic solutions were used:

Mrs. E., æt. 44 years, patient of Dr. A. C. Rembaugh, of this city, did very well after an ovariotomy, on March 9th, 1885, until the 16th, when the sutures were removed from the abdominal incision, and the usual tight dressing was reapplied about the abdomen. Deep-seated pain in the abdomen, with vomiting and obstinate constipation, supervened, until the bowels were moved

with an explosive sound within the abdomen, as from the sudden liberation of pent-up accumulations above an occlusion of the intestinal tract. The urine became more scanty; slimy stools were passed devoid of feces, and the patient succumbed on the 19th. With the experience of the present, the abdominal bandage would have been loosened after the third or fourth day, the bowels moved by enemas of flax and tea, and opium dispensed with entirely, if it were possible to do so.

Great care is needed in the use of sponges within the cavity of the abdomen during an operation, that they do not fret and erode the peritoneum unnecessarily. Such eroded surfaces are very apt to adhere, especially if opium is administered in quantities sufficient to diminish the peristaltic action of the bowels. Nux vom., Bry. or Sulp., by promoting peristalsis, may prove much more beneficial to our patients.

Mrs. R., a patient of Dr. Langer, of this city, was first seen in consultation in July of last year. She suffered from the most intense abdominal pain, with sleeplessness, inability to lie down, and great abdominal soreness. For several years subsequent to the birth of her child, eleven years before, the menses had entirely ceased for three or four months at a time. Recently they had become more regular, but at each period her sufferings were very much intensified. On an examination, an ovarian cyst was found on the right side of the uterus, which reflected the fundus to the left side of the pelvis, and another cyst was found in close proximity to the fundus, but back of it. At the operation the pedicle of the first tumor was found to consist of the left broad ligament, considerably elongated, whilst the other tumor with a short pedicle had developed from the right ovary. The impaction of the tumors with the uterus accounted for the intense suffering this patient endured for so long a time.

The fluid from the larger cyst was dark, as was also the cyst wall, but devoid of offensive odor. That from the small cyst, which had a very short pedicle, was thicker and of the peculiar pea soup appearance, so often seen when ovarian cysts are evacuated before degenerative changes have taken place from a constriction of the pedicle. This patient had become so accustomed to the use of large doses of morphine that it seemed to have no effect in quiet-

ing her after the operation or inducing sleep. It was inert, or worse than useless even, in doses of a grain at a time, for it made her crazy. Diarrhœa set in on the third day, which Rhus controlled very nicely, and Bell. given at night enabled her to get a little rest. Under its influence, the skin became more active and the urine more copious, and through the whole treatment, the kidneys and skin never failed to perform their functional action satisfactorily. She sat up on the fourteenth day, but it was a long time before she regained control of her nervous system. But it is from the experience of writers, the best part of whose lives has been especially devoted to this work, more than that of my own, that I am lead to conclude that there is ground for the belief that the principles of homœopathy can be successfully applied to abdominal surgery.

One of the most successful ovariotomists in the Dominion of Canada recently declared that after an operation, he needed no medicine except when there was vomiting, when he directed the patient to sip hot water, or prescribed Ipecacuanha in homœopathic doses, preferring the third dilution. He also states that before an operation he avoids purgatives as much as possible. It is by attention to these little details that we turn the balance for or against successful results in many instances. And the truth always leads its votaries to tread a similar pathway.

DISCUSSION.

Dr. B. F. Betts opened the discussion by exhibiting Molesworth's new dilator. He then said that the case reported by Dr. Mercer was interesting, because for twelve years fibroid growths developed in and were expelled from the cavity of the uterus, and upon one occasion, during the expulsion of one of these growths, the uterus became inverted, so that the doctor had the opportunity of seeing the entire mucous membrane of the uterus, and was enabled to determine that there were no polypi left, and yet, in two years, another mass was expelled. After that was removed, cancerous degeneration ensued, and the patient died. The speaker next proceeded to review Dr. Smedley's paper, in which the writer

called attention to the importance of the immediate operation for laceration of the perineum. Attention was directed to the importance of slight tears, which are frequently overlooked, and also to tears down the posterior vaginal walls, which do not extend into the perineum. Inasmuch as such tears weaken the floor of the pelvis, it is important that they be brought together immediately. These tears may often be detected by the finger, especially after forceps delivery. Dr. Smedley called attention to the employment of catgut in the closure of these rents. That point Dr. Betts emphasized. Dr. Betts also referred to the performance of certain operations on the vagina without the use of sight by Mr. Lawson Tait. He thought we should all follow the example set by this operator.

Dr. J. H. McClelland did not think that the expansive power of the Molesworth dilator amounted to more than an ounce or two. He also thought that where the resistance was very great the piston was apt to slip out from between the blades and do some damage. He then referred to Ellinger's dilator, which he thought was a perfectly safe one, and which he had used in many cases of anteversion, of dysmenorrhœa, and of sterility, with excellent results and without any bad effects. As to turning of the instrument *in situ*, he thought that that would be a frightful thing to do with the instrument already dilated; hence he thought that the safest plan is, before turning, to let the blades go down to their undilated state entirely, because if they remain only a little open they are liable to tear the mucous membranes. The dilator is thus, for all practical purposes, made into a sound, when it may be turned around.

Dr. I. G. Smedley asked if Dr. McClelland had ever had any bad results from Molesworth's dilator.

Dr. McClelland replied that he thought that he had done harm with the plunger, because of the insecurity of the blades.

Dr. Smedley said that he was glad to learn that, when he first saw the instrument, he offered the same objection as does Dr. McClelland. The inventor said, however, that the cervical canal would offer an even resistance all the way round, and it would be impossible for the plunger to go straight. Dr. Smedley's experience agreed with this. He had now used this dilator a number

of times without any accident, but he would observe great precautions in the future, in view of Dr. McClelland's results. He thought that Ellinger's dilator, of which Dr. McClelland spoke, could not be used in cases of stenosis of the cervix, as it would be impossible to introduce it. Molesworth's dilator is small enough. He did not think that the blades of a dilator would slip out, if the cervix was carefully held by forceps while the instrument was being used. Sight should always be used during the operation, in order to see what the instrument is doing. If the blade should slip out, the plunger should always be removed before re-introducing the instrument.

Dr. McClelland replied that he had found the blades of the Molesworth dilator to slip out, although he had held the uterus firmly with a tenaculum. The Ellinger dilator did not slip. In using this dilator in cases of stenosis, he always inserted a small instrument first. After that, he would use a larger one. Dr. McClelland also observed that if in trying to introduce a dilator into the uterus, one makes steady pressure with the instrument, the fibres will give way in a most amazing manner, so that in time, a large instrument may be made to pass.

Respecting dysmenorrhœa from ante-flexion, the speaker said that for years, a relation will be observed between the two, and then some one comes along, and attributes the dysmenorrhœa to entirely different causes than the flexion. He did not think that the observations of one man should be permitted to upset the experience of years. Every one knows that a bent cervix will produce dysmenorrhœa by obstructing the cervical canal.

Dr. M. J. Buck asked if all cases of anterversion or ante-flexion produced sterility.

Dr. McClelland replied that they only did so when sufficiently aggravated to obstruct the cervical canal.

Dr. M. S. Williamson asked when was the proper time to find out whether there was a laceration of the perineum. The proper time to note laceration of the cervix, is during the escape of the placenta. He thought that the same would apply to the passage of the placenta through the external passage.

Dr. Smedley replied that the proper time to examine for laceration of the perineum, is immediately after the delivery of the pla-

centa, and for this examination, sight should be used. He, himself, never felt satisfied until he had exposed the parts carefully to see if there was a tear there. Frequently, it had seemed to him when examining by touch, that there was a laceration, the parts were so stretched, when inspection showed the perineum to be intact. He did not believe that these operations could be done without the aid of sight, on account of the necessity for perfect cleanliness and the removal of ragged edges.

Dr. Betts fully agreed with the value of Dr. Williamson's proposition respecting the proper time to examine for lacerations of the cervix and perineum, his suggestion respecting the latter being a new one. In recommending the repair of lacerations without the aid of sight, he referred only to vaginal rents. Lacerations of the perineum, he thought, ought to be treated with the aid of ocular inspection. He would especially urge upon members the value of acquiring the ability to diagnose and treat these vaginal rents by touch alone, as it is impracticable to always have suitable specula at hand.

Dr. Chas. M. Thomas asked Dr. Betts as to the results obtained in these operations.

Dr. Betts replied that he had examined some of these cases at the end of six months and found the results satisfactory. In all cases, it is his practice to examine the patient eight weeks after confinement, and he has invariably found good union after the operation.

Dr. Thomas said that he had had not a small experience in the restoration of lacerations of the perineum. In these operations he had used catgut for a number of years. In ninety per cent. of his cases he had found it necessary to run the line of denudation up to the uterus. He thought that there was a possibility in these cases of the parts being left relaxed, with a tendency to rectocele, although the original tears may have healed. In cases coming to us having secondary relaxation, we almost invariably find no trace of laceration. He doubted, very much, if any one could unite a rent in the vagina without looking at it. In the first place, the raw surface is covered with the lochial discharge, and, in the second place, with numerous ragged shreds of tissue, which must be removed. It will be a difficult matter to make out the presence of

these ragged edges by the finger alone. His practice in recent cases of laceration is to introduce the speculum, and place a carefully prepared sponge in the vagina, to control the flow of blood. Then he irrigates the wound very freely with solution of bichloride of mercury. During this last-named process the shreds make their appearance, when they can be removed. Then he introduces his sutures, the first one at the upper angle.

Dr. Betts asked if Dr. Thomas had ever been called upon to close lacerations of the vaginal walls, in which there was no involvement of the perineum.

Dr. Thomas replied that he had met with quite a number of such cases.

Dr. Betts asked what was the cause of rectocele, when there is no laceration of the perineum.

Dr. Thomas said that in the majority of cases the rectocele was the result of posterior laceration of the vagina.

Dr. Betts asked what would be the treatment in such cases.

Dr. Thomas replied that the treatment was such as he had already described. He did not believe that we can accurately close these rents if we do not see the parts. Still he had never tried it.

Dr. Betts remarked that if Dr. Thomas would try it, he would find it a very easy thing.

Dr. Thomas said he would much prefer the aid of sight in performing the operation.

Dr. Betts said that when a consulting surgeon is called in, the patient expects to be examined thoroughly and in every possible way, but with us, who attend to general practice, she thinks very strangely of it.

Dr. Thomas asked if Dr. Betts could make out ragged edges by touch.

Dr. Betts replied that he could in a majority of instances.

Dr. Thomas suggested that Dr. Betts examine his cases one year after the operation to see if there was any rectocele.

Dr. D. Cowley asked Dr. Betts how it was possible to secure the consent of his patients to an examination eight weeks after delivery.

Dr. Betts replied that he had found that patients appreciated the extra attention. They look upon it as necessary. Many of

the ills incident to women are the result of lack of attention after confinement. In the country districts it is customary to discharge the physician at the end of two days; in this city, on the tenth day. In New York it is an almost universal custom among obstetricians to see their patients at the end of six weeks. If you tell patients why you wish to make the examination, they will appreciate the attention, and they will think more of the physician. These late examinations are of advantage to the physician, in that they convince him that he has left his patient as he ought to leave her—a perfectly healthy woman. If, at this time, he finds a tear, he can let the patient know of it, and then measures may be adopted for closing it.

Dr. Cowley said that such proceedings would institute a new custom in his district.

Dr. McClelland said that he had followed the practice, outlined by Dr. Betts, for years.

Dr. J. F. Cooper said that the making of thorough examinations of cases several weeks after delivery would be kindly received only where such procedures were customary. In places where it is not the style, it will surprise the patient.

In regard to the time of discovering lacerations, he believed the proper time to be during the escape of the placenta from the uterine cavity. One cannot, however, always embrace that moment, because the hand is not always free. In discovering the laceration of external parts, it has been customary with him to do so by passing his finger down the posterior wall of the vagina. He had never found it necessary to use sight for the discovery of these lacerations.

Dr. M. J. Buck asked Dr. Betts what he thought of the value of episiotomy in the prevention of perineal lacerations.

Dr. Betts replied that he had resorted to that measure several times, but had not obtained any striking results therefrom.

THE REPORT OF THE BUREAU OF SURGERY

Was presented by the Chairman, Dr. L. H. Willard, of Allegheny City. It embraced the following papers:

Supra-pubic Lithotomy, by Charles Monroe Thomas, M. D., of Philadelphia.

Resection of the Colon, by J. H. McClelland, M. D., of Pittsburgh.

Remarks on Internal Urethrotomy, by W. B. Van Lennep, M. D., of Philadelphia.

Tetanus, by E. Reading, M. D., of Hatboro.

Surgical Cases, by W. R. Childs, M. D., of Pittsburgh.

Resection of the Knee Joint, Complicated with Chorea, by L. H. Willard, M. D., of Allegheny City.

SUPRA-PUBIC LITHOTOMY.

BY CHARLES MONROE THOMAS, M. D., PHILADELPHIA.

The high operation for stone, though steadily growing in favor for the past few years, has quite recently received a more positive impulse through the publication of a large number of interesting cases at the hands of well-known operators. Indeed, in the light of our present experience, it becomes almost a matter of astonishment that this operation should have so long been kept in comparative obscurity.

Its more extended application may, in this country, at least, be traced to the numerous carefully prepared papers and statistics of Charles W. Dulles, William Tod Helmuth and a few others.

During the past three years, however, by far the largest number of cases have been found in the reports of European surgeons, more particularly those on the Continent of Europe, of which the most prominent are Peterson, Trendelenberg, Bergmann and Guyon, and quite recently in England, Sir Henry Thompson, who speaks highly in its praise, and reports seven cases, with one death.

In a discussion at the Congress of German Surgeons for 1886,

on a paper by König, of Göttingen, concerning the choice of stone operation, opinions seemed about equally divided between the median and high method, the lateral operation being advocated by very few. Bergmann of Berlin reported nineteen supra-pubic lithotomies with but one death, and that not traceable to the operation itself. Trendelenberg gives ten cases, with one death.

The following is a brief report of my experience with the high operation, covering a period of the past twenty months.

Case I., æt. 67 years.—A patient of Dr. Curtis, of Wilmington. The high section was done on account of a probable sacculation and large size of the stone. The bladder was washed and distended with weak iodine water. The rectum was not inflated. The incision was completed with no difficulty, and the bladder incised on the beak of the silver catheter, which had been used for the injection, a stout thread having first been passed into the fundus to prevent the viscus from sinking below the pubis. The stone was easily reached with the finger, but dislodged with some difficulty from its bed behind and to the left of the prostate. Delivery was then quickly made with forceps, though the stone proved to be above the average size, weighing three ounces.

An unsuccessful attempt was made to suture the bladder, owing to the thinness of its walls, and its deep seat below the very fat abdominal parietes. The angles of the skin wound were united for a short distance, and a long, large rubber drain introduced into the interior of the bladder and fixed in position by a single silk stitch to the integument. The bladder was now thoroughly washed out from the urethral side, and the soft catheter used for this purpose left in position *a demeure*. The seat of operation was surrounded by masses of absorbent cotton, and the patient placed on his side with hips somewhat elevated. The wound granulated with no untoward symptoms, though slowly, and leaving a fine fistula, which did not close till several months later.

Case II., æt. 66 years.—High operation was done at patient's request, there being no contra-indication for the perineal incision, except, perhaps, the presence of a very large, hard prostate. In this case, the patient being thin, the distended bladder could be plainly felt and seen above the pubes before the incision of the integuments. No staff or catheter was used as a guide in opening

the bladder. The vesical wound was closed with a continuous suture of gut, and the abdominal cut united down to the lower angle, when a thick rubber drain was inserted. In-lying, catheter was used. Urine appeared at the wound in thirty-six hours, when all the integument stitches were immediately removed, and the edges allowed to gap. The depths of the wound were now freely injected with idodized water every few hours, and the bladder flushed through the inlying cathater at the same time. The urine ceased to appear at the wound after ten days, and healing was complete in five weeks. with no drawbacks. The rectal distension was used here. The stone of the mixed variety weighed five drachms.

*Case III., æt. 47 years, was a patient of Drs. Childs and McClelland, of Pittsburgh. The *sectis alta* was chosen on account of deep perineal sinuses fistulæ, etc. Both rectum and bladder were distended. A silver guttered-catheter was introduced as an injector and guide, but not used for latter purpose. The course of the operation presented nothing of special interest. Bladder was closed with a combination of the Lembert and continuous stitch. On the fifth day, there was a flow from the wound of a clear odorless fluid, the quantity of which was apparently not influenced by the amount of urine in the bladder. This discharge continued more or less profusely for ten days, without causing any complication. Recovery was complete in four weeks. The weight of the calculus was 200 grains.

Case IV., æt. 70 years, a patient of Dr. David Gardiner, was very feeble and prostrated by long suffering. Had been bed-ridden for several weeks. Urine loaded with pus and exceedingly offensive. The clarified urine showed albumen and tube casts. There was constant desire to urinate, and almost constant stillicidium. By the use of the syringe, the bladder could not be made to hold more than 3 to 4 ounces. The stone could be grasped by the lithotrite, but owing to the limited size of the bladder, the idea of lithotrity was abandoned and the high operation chosen. On injecting the bladder, instead of the usual hemispherical tumor appearing back of the pubes, a long ovoid enlargement bulged up beneath the thin abdominal walls, well off in the *right iliac* region.

*Reported in *Hahnemann Monthly*, of April, 1886.

The small bladder could be indistinctly felt below the pubis. On incising the bladder, the walls of which were quite thick, the interior was found very small, and holding a little phosphatic stone which was readily removed. On further exploration, the oval iliac swelling proved to be a long diverticulum connected with the bladder; the opening between the two cavities being only large enough to comfortably admit the index finger. This sac also contained a stone larger than the first. Its removal was attended with much difficulty, owing to the small size of the entrance to the diverticulum, and could only be accomplished by crushing it and flooding out the fragments, with the patient rolled on to his face. The fragments collected from the second stone, also phosphatic, weighed 170 grains, the one taken from the bladder proper, 80 grains.

In this case no effort was made to close the bladder. The after, treatment was essentially the same as in Case 1. To my surprise, but little immediate shock followed the operation, and no bad symptoms were apparent for twenty-four hours. From that time, however, till his death on the six day, his strength gradually failed—the fatal issue seeming to be due to a simple lack of recuperative power. At no time was there any sign of peritonitis or unfavorable inflammation in the wound, or a decreased action of the kidneys. Autopsy was not obtained.

Case V., æt. 63 years, had had symptoms of stone with vesical blenorrhœa, for several years, but careful explorations by skillful surgeons, had failed to detect a calculus, previous to his application to me. With a short beaked Teevan explorer, I succeeded in touching the stone far to the right of the prostate; and in no position of the pelvis could it be felt in any other location. The examination, though a cautious one, was followed as on the previous explorations by bloody urine. The discharges from the bladder were and had long been purulent and offensive. Suspecting encapsulation the high operation was performed, and the stone found imbedded to the right of and between the prostata. Enucleation and extraction were accomplished with but little difficulty. Both bladder and rectum were distended, but no staff guide employed. No stitches were introduced, excepting at the extreme angles of the abdominal section. After treatment by long large drain as already

described. The inlying catheter not assisting in the drainage, was removed after twenty-four hours, and only introduced at intervals of four to six hours, for the purpose of washing out the bladder. Recovery was uninterrupted, and the case was dismissed healed in twenty-eight days.

REMARKS.—In none of my cases was the peritoneum seen, though in Case 3, in seeking for a reason for the free watery flow from the wound, Dr. McClelland, who conducted the after treatment, suggests the possibility of an unnoticed small wound of the peritonum as the source. If the character of the cases and the age of the patients be considered, (all except one over 60 years,) the loss of one case in the five, may, I think, be looked upon as a very fair if not unusual showing for *any* form of lithotomy. Indeed in cases 1, 4 and 5, the completion of the operation by any other method than the supra-pubic would have been a matter of difficulty if not impossibility. In case 1, the stones would almost certainly have had to be crushed through the wound before extraction by the perineum, and in case 4, I fail to see how the second stone could have been reached at all by the low operation; and in this instance the fatal result cannot well be traced to the method of operation employed.

In the treatment by the *open method*, I have in each instance found that the inlying catheter was practically useless as a drain to the bladder, and in future I should only introduced it when required to flush the organ, as in case 5. When the bladder suture is employed and the closure complete, the more or less constant use of the catheter is of course a necessity, and its action is usually all that could be desired.

While the distension of the rectum no doubt tends distinctly to increase the space for operation, I have found it to decidedly interfere with the extraction of the stone, after the bladder is evacuated of its fluid contents, and have been obliged to let off the water from the rectal colpeurynter as soon as the interior of the bladder was exposed.

When the bladder can be distended, I can see no necessity for the use of a guiding staff or *sond a dart*, and did not employ one after my first case.

It appears to me that one of the most important points in the pre-

vention of urinary infiltration and cellulitis is the avoidance of tearing, bruising, or even much manipulation, or fingering of the fat and connective tissue below the abdominal aponeurosis. Clean cutting is just as clearly called for here as in the overlying tissues, and I cannot but express my surprise at the advice given by Sir Henry Thompson in a recent article, to tear the way to the bladder with the finger-nail, after having passed the muscular aponeurosis.

Whatever may be the scope of supra-pubic lithotomy in the future, it appears to me that it is now certainly called for:

First—When the stone is known to be large, say over an inch and a half in any diameter.

Second—In encysted stones.

Third—In sacculated bladder.

Fourth—In all cases, when the perineal space is decidedly encroached upon by pelvic distortions, tumors, etc.

Fifth—In many cases of prostatic enlargement.

Whether in stones of small or medium size, and in young people it will even supplant the median and lateral operations, is a matter which can only be decided from a very much greater experience with the operation than we at present possess.

In simplicity of execution, it will certainly compare favorably with any of the cutting operations. The only element in its execution which may be looked upon as dangerous is the risk of wounding the peritoneum, and experience has shown this to be not a theoretical risk; in fact it, is certainly at times bound to hap pen. Quite recently Sonnenburg and Gussenbaur have each reported a case in which the peritoneum was found close in contact, and even adherent to the pubis. Fortunately, however, as to the danger of this mishap, it may be looked upon as comparatively small, for when it has recurred even to the appearance of the bowels in the wound, the cases have almost invariably recovered.

Rupture of the bladder and rectum from over-distension in the preliminary steps to the cutting, are accidents which, though possible and have happened, are easily avoided with ordinary care.

By far the geater number of fatal cases have been the result of post-pubic cellulitis; the avoidance and combatting of which, form now the all absorbing study with those who are interested in perfecting this operation. Whether it be better to attempt by sutur-

ing the bladder to prevent the contact of the urine with the wound, or on the other hand, to leave the bladder entirely open and endeavor to lead the urine immediately from the cavity as it enters, is a question difficult to answer at present, though without doubt the method by suture is the ideal one. The proportion of primary union with the suture, though not large, is still sufficiently great to encourage further efforts in this direction. In a publication of 41 cases of suture collected by Meyer, of Germany, in 1885, primary union resulted in 16; and since then numerous successes have been published by various operators.

The positive advantages of the high operation over any form of the perineal method are, the small amount of primary hæmorrhage with which it is attended compared at least with the lateral operation; the fact that each layer of tissue, and even the interior of the bladder, is clearly brought to light as well as to touch, while in all other operations the most important part, the deep incision, must be done out of sight, by the sense of touch alone; the great faculty with which the delivery of the stone can be affected; the avoidance of the well-known evils resulting from interference with the bladder neck and spermatic vesicles.

In cases of very large stones, impacted stones, or when calculi lie in a diverticulum, the high operation is simply above comparison with any other method. Indeed, it would seem that the reduction of pero-vesical cellulitis to a minimum *alone* required to establish this as the universal operation for the extraction of stone by incision.

Since the presentation of this paper to the Society, I have removed by the high section a uric acid stone about an inch in diameter, from the bladder of a boy, 8 years old, a patient of Dr. Snyder, of Ashland, Pa. In this case I met with my first real difficulty, in having to deal with the *peritoneum in close contact with the pubes.* I was fortunately, however, able to push it up, sufficiently to give room for a free incision of the bladder. The bladder was sutured, and united *per primam.* The parietal incision was lightly tamponed with gauze, which was removed on the third day. The boy was up in seven days and dismissed on the tenth day after the operation.

RESECTION OF THE COLON.

BY J. H. MC CLELLAND, M. D., PITTSBURGH, PA.

Mrs. B., æt. 65, a patient of Dr. H. Hofmann, for thirty years subject to constipation, and was accordingly addicted to purgatives; subject to attacks of bilious colic, operations of bowels becoming more difficult. For five weeks she had no motion of bowels. Great abdominal suffering. Enemas had been used *ad libitum.* Bougies. When called, advised exploration by hand through rectum. Under ether I made this exploration, and found a constriction midway up the descending colon. Concluding upon laparotomy, the next day I proceeded to open up the abdomen, finding a cartilaginous constriction, occluding the intestines almost to completeness. Resection was made, taking about two or three inches of intestine and a wedge-shaped piece of the mesentery. The utmost care was taken to secure exact coaptation, and sutures were freely used. The toilet of the peritoneum was perfect. After the operation, the patient rallied nicely, and for hours repeatedly expressed herself as completely relieved of her distress.

The following night, without any apparent cause, the patient began to sink, and when the attending physician, Dr. Hofmann, arrived, she was in a state of collapse, and within a few hours died. I regret that circumstances prevented my securing a post-mortem examination.

About this same time I was called to a case of colic in a gentleman who had been indulging daily, for some time, immoderately in peanuts. The abdominal pains continued, and vomiting set in the next day with increase of distress. The abdomen was swollen but not tender. The bowels were freely moved by large enemas; still the vomiting continued and became stercoraceous after the second day. He continued the fecal vomiting for ten days. The point of obstruction was located in the small intestine, probably in the ileum. The treatment consisted of six quart injections of warm water, four times daily, the drinking also of large quantities of warm water. Internally: Bell., Nux., Plumbum.

I stood ready, day after day, to make laparotomy, but as the strength held out, and inflammatory symptoms were held in abey-

ance, I awaited a favorable termination. After ten days of fecal vomiting, the constriction finally gave way, and fecal matter appeared in the water of the enemas, which had been rigidly persued during this time. Recovery now began, and was complete in about ten days more. This case was remarkable for the long continuance of fecal vomiting.

REMARKS ON INTERNAL URETHROTOMY.

BY W. B. VAN LENNEP, M. D., PHILADELPHIA.

Every originator of a new method of treatment or operation would seem to tend toward the extreme of too extensive application, would make the same a cure all and an infallible one. He is met, however, by a host of opponents, incited, some by personal motives, others by jealousy, but the majority by the above mentioned tendency on the part of the inventor. These decry the same as useless, injurious, etc., in varying degrees, and it is only by the continued accumulation of testimony from disinterested observers that the procedure finds its real place. With this end in view, I propose to relate my experience with internal urethrotomy as devised and taught by Otis, of New York.

I have practiced this operation for over two years, and have a series of cases observed for periods varying from the above down to a few weeks. They have been cut for the relief of gleety discharges, as a rule; for troublesome symptoms of the prostatic portion occasionally; and, in two instances, for almost complete closure of the urethra. The number of strictures has varied from one to six; their location from one to four and a half inches down, the average depth of stricture following urethritis being, from my experience, between two and three or three and a half inches. Hence they have always been anterior to the triangular ligament, or in the superficial urethra, and readily reached by a straight instrument.

In two instances, there has been bleeding requiring attention subsequent to the operation, while but three have had more than the slight febrile reaction we might look for after any surgical

interference. Cutting has been undertaken for hard callous strictures, yielding only to a certain amount of dilatation, and then bleeding readily under manipulation; for elastic, recontracting or resilient strictures, which stretch six or eight sizes, perhaps, at one sitting, but are back again to the starting point at the next. With but one exception, sounds and local and constitutional indications have always been tried first.

I have operated without any anæsthetic, with cocaine, and with ether, and would give the preference, other things being equal, to the latter, on account of the complete relaxation produced, and because cocaine has, in several instances, disappointed me.

The after treatment has with some been *nil;* with others a course of sounding extending over a period of three weeks, during which the discharge of healing dries up. As a rule, the latter have done better. With this, have been associated mild local applications of one form or another by means of injection, medicated bougie, or painting through the endoscope.

The majority of cases have been markedly benefited or cured of the troublesome symptoms; in a number, too, I have been able to find a "catch" with the bulbous sound at one or more points cut. In some the symptoms recur with the recontraction, in others they continue in its absence. In some, they disappear when this constriction is removed by a second operation, in others they do not. I ought to add, in justice to myself, that this recurrence or failure, if you please, has not been more frequent in my earlier than in my later operations. A certain number of failures are undoubtedly due to follicular disease which often seems almost impossible to cure, unless, perchance, it be kind enough to cure itself. A word concerning the *technique* of the operation may not be out of place.

The first step is to ascertain the full capacity of the urethra and accurately locate and measure the stricture or strictures. This is readily done with the urethrometer. The meatus and superficial constrictions are then cut to the full size with Otis' dilating urethrotome. I use this method almost entirely in enlarging the entrance to the urethra. The pressure seems to benumb the pain and the register enables one to be much more accurate than with the knife; the bleeding, too, is less troublesome.

The tightest stricture, usually the callous one, is then stretched and incised. My instrument registers one size too large, and in my later operations I have purposely overstretched and consequently over incised the stricture. This is repeated if necessary until the urethrometer detects no "catch," and then the remaining constrictions, of which there are almost always one or more, situated anteriorly as a rule, are treated in a like manner.

It is hardly necessary to add a word in favor of cutting a tense stricture as compared with the older methods ; Otis has argued the matter at length and in a convincing manner to American surgeons at least.

In incising a stricture, I take pains to have the knife look upward as nearly as possible in the median line. As a result the consequent bleeding is, to my mind, very much less, and in the two cases when bleeding was at all troublesome I neglected to do this.

Another precaution, and by no means an unnecessary one with the instrument in question, is to have the knives *literally* sharp. I once tried to operate with a dull knife, and since that time have them ground immediately after use.

The operation done, a large Nelaton catheter is introduced to the bulb and a warm antiseptic solution freely injected. It runs out alongside the catheter, of course, and very soon flows clear, however free the hæmorrhage. This is repeated if necessary after each urination for from 24 to 48 hours. Bleeding usually accompanies the flow of urine and erections, but has, in every instance, yielded as readily to the washing as at the time of operating. The penis is gently bandaged, a folded napkin laid over it as a pad, which is held in place by a towel or bandage fastened front and back to a waistband, thus allowing the patient to make considerable pressure by traction on the same.

The account of a few cases may be of interest.

I. Mr. A., clerk, between 30 and 35 years of age, came to me in the summer of 1884 with a chronic but free urethral discharge and a left sided epididymitis. On the subsidence of the latter, I found, on examination, a clean cut, short constriction a trifle over three inches down. It admitted a No. 27 (French) sound, and, to make a long story short, was, with considerable difficulty, gradually

dilated to No. 36. In the meanwhile, he had topical applications and several remedies.

The urethral capacity was full No. 45, but beyond No. 36 the stricture would not stretch, each sounding, too, being followed by free bleeding. To complicate matters, the epididymitis relapsed, and he was induced to try urethrotomy.

I operated with the patient under ether, and by two stretchings and cuttings brought the stricture up to No. 46. No other constrictions were present, and he recovered without a bad symptom and without after treatment. The discharge ceased, and nearly a year afterward I was unable to find any sign of stricture. This is the largest urethra I ever met with,

II. Mr. S., mechanic, æt. 33 years, was sent to me on account of symptoms that caused a suspicion of stone. I examined him carefully and made out a decided prostatic catarrh with extreme hyperæsthesia. He positively denied having had a urethritis, and I began with five drop applications of a five per cent. solution of nitrate of silver to the prostatic urethra, together with pressure to the same by means of cylindrical sounds. When I reached No. 29 (French) it was arrested at three and three-quarter inches, and I found there a hard, resisting constriction that refused any dilatation. The urethral capacity was found to be No. 35, the stricture measuring No. 28, while anterior to it was another of larger calibre. They were both cut and a No. 35 sound readily introduced; the patient being etherized the deep urethra and bladder were carefully examined. There was next to no bleeding, the annoying perineal pains and dysuria disappeared, and the urine cleared up. On the second day, however, the patient had a severe chill followed by high temperature (104°) and a sweat. He received Aconite, but the chill recurred with a sweaty fever and symptoms indicating Gelsem. Still the fever continued with occasional chills and sweating at irregular intervals until it assumed a typhoid character. Baptisia seemed to clear up everything and he is now in a fair way to recover.

III. Mr. J., merchant, æt. 31, came under my care in January, 1885. He had had several attacks of urethritis, and, for a long time, had never been free from a slight urethral discharge, which seemed constantly inclined to spring into full bloom on the slight-

est provocation. He had been the rounds and tried everything. I found a contracted meatus, a constriction behind the fossa navicularis, a stricture through which a No. 30 sound could, with difficulty, be squeezed just short of two inches down, and another admitting a No. 27 nearly two inches further. Both constrictions would only give two or three sizes, while the urethral capacity was No. 37.

Using a four per cent. solution of cocaine as an anæsthetic, I brought them up to full No. 37; fifteen months later, a No. 37 bulb went through the urethra as smoothly as it did immediately after the operation. There has been no recurrence of the discharge. Patient had two smart hæmorrhages following erections, on the second and eighth days.

IV. Mr. C., salesman, consulted me concerning a urethral discharge he had been troubled with for about fifteen years, every over-exertion or sexual indulgence bringing on a profuse flow. His urethra measured No. 43, and, besides a contraction at the orifice, there were three strictures, approximately at one, two and four inches. They could be stretched with considerable force to No. 40, or even No. 41, but would bleed quite freely and require, at the next sitting, a No. 33 or No. 34 to begin with, so rapidly did they contract.

Urethrotomy was performed without an anæsthetic, at his request. At the first sitting I cut the two anterior strictures, freely over-incising them. At a second sitting, number three was treated in like manner. Still the discharge continued, and three months later I again cut a "catch" I found at stricture number two.

There was no apparent change in the flow, which still resisted every topical application and internal medication imaginable. I gave him, among other things, Hydrast. sulph. as an injection, and, to my surprise, for it had hitherto always disappointed me, the discharge was checked at once. It recurs, however, to this day from the same exciting causes; it is bland, milky and profuse, unaccompanied by pain or inflammatory symptoms, and, from what I can learn, is non-infecting. About five months after the last cutting, I examined the urethra, but could find no sign of stricture.

V. Mr. M., sixty odd years old, contracted gonorrhœa when a young man, and used "very strong injections of nitrate of silver."

He had noticed that, for some time, the stream of urine was getting smaller, and that he was obliged to use a good deal of force to expel the same.

I succeeded, with some difficulty, in getting the smallest filiform bougie into the urethra, and had to use considerable persuasion to make it advance. By degrees, a second was insinuated alongside, then a third, and so on until the urethrometer could be made to enter the canal. I found a capacious urethra measuring No. 35 or No. 36 up to within two and a quarter inches of the meatus; from that point on was a hard cicatricial tube. I cut up and down at several sittings, until I could readily pass a No. 35 sound. There was immediate improvement, which has continued, although the tendency to recontraction requires a stretching about once a month.

I would, in conclusion, heartily endorse internal urethrotomy in hard, callous strictures, which resist complete dilatation and in those which constantly contract, elastic or resilient ones. In tight stricture, we must come to this procedure sooner or later in most cases. In giving a prognosis, however, we must remember follicular disease, and, in rare instances, an atonic condition of the mucous membrane. We can, I think, perform the operation with every promise of success in cases of prostatic disease, catarrhal or nervous, when such a stricture exists in the anterior urethra.

I am decidedly opposed to internal urethrotomy beyond the bulb; hæmorrhage is apt to be severe, and is hard to control, and reactions are frequent and dangerous. Further, the apparent constrictions in the triangular ligament, in many instances, certainly depend upon and disappear with the anterior strictures, while those of traumatic origin, so common in the membranous urethra, are best treated through a perineal incision.

TETANUS.

BY E. READING, M. D., HATBORO.

Tetanus is an affection almost always the result of injuries, though sometimes occurring without any known cause, and is

characterized by a permanent and painful contraction of the voluntary muscles of the body, rendering it rigid; usually commencing in the muscles of the jaws and neck, and gradually extending to the other muscles of the body; and is accompanied by severe convulsive paroxysms.

Tetanus may be designated as either traumatic or idiopathic, either acute or chronic, or it may attack different sets or groups of muscles; thus when the jaws, throat and neck are affected it is called trismus or true lockjaw; opisthotonus, when the back is most affected; pleurosthotonus, when the sides of the body are attacked; and emprosthotonus, when the abdominal muscles are contracted.

Causes: Although the disease generally results from wounding the body, yet the principal cause of the disease is to be found in the state of the patient and the conditions that surround him. Persons residing in a malarial district, or in a cold, moist atmosphere, are more liable to contract the disease, but the nature of the wound, the particular part affected, the injury to a nerve or the pressure upon a nerve, from its being involved in a cicatrix at its extremity, may have a tendency to produce the disease; the subcutaneous injection of morphia having in one case, to my knowledge, caused the disease in a severe form. The disease occurs most frequently and in severer form among negroes, which may be accounted for, by their mode of life and exposure to climatic changes. The size of the wound does not seem to be of much consequence, as severe laceration or contused wounds may heal readily, and the disease follow a slight puncture, but the part affected does have much to do in developing it, as it more frequently occurs from wounds in the tendinous parts, that are well supplied with nerves, as the hands and feet.

The principal cause of tetanus, however, is exposure to a cold, damp atmosphere, as lying in a draft of air during the night, or from insufficient covering in cold weather. Mental depression is, also, a joint cause with cold.

Some authors admit contagion as a possible cause. Betoli reports the case of slaves who died of tetanus, after having eaten the flesh of a bull which had died of this disease; but this, to say the least of it, requires, before it is received as a cause of this disease, further investigation.

The spinal cord is the seat of the disease, the irritation extending to the whole nervous system, but lesions are more frequent in the spinal cord than elsewhere, and investigation, after death, reveals no traces of anything but a simple irritation of the nerve elements in any other part of the system.

Of the nature of tetanus, there is a wide difference of opinion, some adopting the humoral theory, thus seeking for its origin in the alteration of the blood; others adhere, with equal tenacity, to the nervous theory, the primary irritation being in the extremities of the nerves, and from them extending to the nerve centres, causing excitement of the spinal cord, which is manifested by two sets of symptoms: one constant, the more or less generalized contraction of the muscular tissue, the other inconstant and variable, an increased temperature of the body. The patient is first seized with a slight trismus, stiffness of the muscles of the neck and lower limbs, and any effort to separate the jaws only increases the contraction of the temporal and masseter, which soon become hard and bulging, and soon present that peculiar appearance of the physiognomy called *risus sardonicus*, the abdominal muscles harden, and those of the vertebral column draw the body backward, producing the condition termed opisthotonos. As the disease progresses, the contraction becomes almost continuous; and there are also very violent paroxysms of the muscles of different parts of the body, which cause the patient intense suffering and extort cries of anguish, and wishes for speedy dissolution.

In regard to the duration of tetanus, the more rapid the more dangerous, as these are invariably the most fatal, while the slow form of the disease most generally ends in recovery: the first sometimes ending in death in a few hours, while the latter runs its course in six weeks or two months.

The treatment of tetanus, which is the part to which I wish more particularly to call the attention of the members of the Society, I am happy to say, has been much more successful under homœopathic medication than any former mode of treatment. The patients should be placed in a well-warmed room, where they can be secure from noise or excitement, and should be kept well protected with light but warm covering. These precautions are the more necessary, as they will prevent the external excitement

which determines most of the paroxysms. If the disease is caused by a wound, the latter should be well examined and thoroughly cleansed, and if necessary enlarged and suppuration promoted by warm emollient poultices.

The remedies that have been most useful in the cases that have come under my observation are: Acon., Bell., Cupr., Nux vom. and Opium. The following cases best illustrate the mode of treatment:

Case I.—Edward M., æt. 22 years, large, robust, weighing 170 pounds, usually healthy, received a gunshot wound in posterior tibio-fibular region of his leg, which carried away almost all the muscles except a few fibres of the gastrocnemius, and superficial fascia at the back part of the calf of the leg; but did not destroy the posterior tibial artery, but produced very severe lacerations of the parts, through which I could pass my whole hand. The case progressed very favorably for about ten days, when, in consequence of the carelessness of the nurse in letting his room get cold during the night, he had a chill, which was immediately followed by stiffness of the muscles of the jaw and neck, and pain in the back. I prescribed Acon., a few drops of the tincture in water: on the next day regular paroxysms had set in; although the temperature had very much decreased, Nux vom.[1] was given and on the day following there was but little difference in his condition, except that he was unable to lie in bed; he had to be placed in a chair, his legs tied together, his hands tied to the chair, and the nurse had to be constantly on hand to hold his head during the paroxysms; in this condition, firmly tied in the chair, he spent most of his time for the next two weeks, only going to bed for a few hours every night to get some rest, to do which it was necessary to give him small doses of morphia.

His paroxysms were very severe; his lower extremities were thrown apart with such force as almost to disarticulate them at the hip joint; his arms were drawn outward and backward, and his teeth, which would be slightly apart between the paroxysms. would come together with such force that he frequently bit off quite large pieces of his tongue, as the nurse did not keep the piece of rubber which she was ordered to have constantly between his teeth. For several days following, he was in very much the same condition, during

which time, he took Bell. and Nux vom., both in the first attenuation, when the paroxysm gradually subsided, and improvement, both in the wound and general condition, continued to his convalescence under the remedies.

I do not think this patient would have had tetanus had he been properly cared for. I considered it one of the most severe cases of the disease and the recovery of the patient shows the efficacy of homœopathic treatment in this affection.

Case II.—Charles C., æt. 28, a farm hand, of rather bad habits, had received a cut on his leg just below the patella and neglected to do anything for it; got drunk; laid out all night, late in the Autumn; was taken with a severe attack of tetanus. This case, though not so bad as the preceding one, was treated alone with Bell. and Nux, a few drops of the tincture in a half glass of water; taken every half hour, and was well in a week and able to resume work.

Case III.—Mary C., æt. 32, had neuralgia in her head; had been treated by an allopathic physician who administered hypodermic injections of morphia. Two days after I was called to attend her, and found her suffering with trismus and constant drawing of the muscles of the back with slight paroxysms. As the temperature was high I gave her Acon. On the next day I found but little improvement; paroxysms more severe; gave Nux, from which time she improved, and, under the use of Bell. and Nux, was well in ten days.

Case IV.—Charles T., æt. 5 years, of nervous temperament, had a finger of his left hand caught in the cogs of a corn-sheller, and very much crushed; should have been amputated immediately, but his parents were not willing. Case progressed very well, for a few days, except that there was not enough vitality in the wounded part to heal rapidly. Exposure brought on tetanus; on being called to visit him I found symptoms of the disease in its worst form. I immediately amputated the finger and gave him Nux, but did not find him much better the next day; but under the use of Bell. he improved very much, and in two weeks was well.

Another case that was of a very severe character, that I was called upon to attend in connection with a neighboring physician, under the same mode of treatment, seemed to rapidly improve

but in consequence of not being properly cared for and kept out of a draft, for he would persist in lying near the window with scarcely any clothing on him, was suddenly taken worse and died in twelve hours; thus showing how careful we should be in our instructions to those who have charge of patients with this disease.

SURGICAL CASES.

BY WM. R. CHILDS, M. D., PITTSBURGH.

Cystic Tumor.—Mr. H. K. G., æt. 23, private patient in Homœopathic Hospital, admitted Aug. 13th, 1886. When a child he had an attack of measles following which there was an enlargement noticed upon the neck between the parotid and sub-maxillary glands. Year after year it gradually increased. At the age of twenty the tumor was diagnosed as cystic, an aspirating needle revealed pus, and the sac was evacuated. This operation was repeated every six months for the last three years, yielding a flow of about a pint, each time, of a yellowish pus. Owing to the pain, inconvenience and unsightliness of the tumor, the man came to the Hospital for surgical aid. A consultation of the surgical staff was held. Patient anæsthetized and tumor removed by making a straight incision of four and a half inches, and then enucleating the sac, which lay with its inner wall upon the arterial trunks of the neck. There were no vessels to ligate. The wound was closed with wire sutures and dressed with iodoform and antiseptic gauze. On the third day the dressing was removed; wound looked well. On the sixth day sutures were removed and wound dressed with balsam of Peru cerate, and on the eighth day, the patient was discharged.

The internal treatment was Arnica^{3x} the first three days, afterwards Bell.^{3x} pro-re-nata. Sept. 6. Patient reports by letter as feeling well.

Orchitis.—Mr. H. G., æt. 26, admitted to Homœopathic Hospital Dec. 24, 1885. In September last he had an attack of orchitis, the result of exposure to cold, from which he recovered in about three weeks. Since then he has been free from any recurrence of

the trouble until four weeks ago when the disease again developed. At present there is swelling of the right testicle with redness, and dull aching pain extending upwards into the right side, worse at night. Remedies and local applications have been applied but with no relief whatever. Swelling is increasing very rapidly. Tumor hard and painful.

Jan. 16.—Consultation of the surgical staff. The testicle was removed entire, the cord ligated, the wound filled with iodoform and united with silver wire sutures. ℞ Arnica^{3x}.

Jan. 27.—Dressings removed, wound is looking well, and dressings renewed. Complains of some pain in side and back. ℞ Rhus tox^{3x}.

Feb. 3.—Elevation of temperature, 104°; pulse, 130. Slight delirium. No pain. ℞ Bell.^{3x}.

Feb. 4.—Scrotum and penis red and swollen and tender to touch. Dressed during the day with hot compresses every hour, at night with hot poultice every three hours. ℞ Same.

Feb. 9.—Some redness of the surface of the body and of either hip near scrotum. The parts were bathed in ten per cent. solution fl. ex. Bell. every two hours, and a compress applied, wet in the same solution. Penis and scrotum less swollen and not so painful. Temperature, A. M., 100.2°; P. M., 103°. ℞ Bell.^{3x}

Feb. 13.—Redness is less marked over hips and lower part of the back, but is extending upward toward the shoulders. Temperature A. M. 160°, P. M. 98.5° Treatment continued the same. ℞ Bell.^{6x}.

Feb. 15.—Patient feeling better, appetite is improving. But little redness remains, and that is rapidly disappearing. The ligature around spermatic artery came away to-day. Wound looks well. Temperature normal. ℞ Bell.^{12x}.

Feb. 18.—No redness of skin and desquamation is taking place. Some tenderness over right groin and of cord. Poultice every 3 hours. ℞ Bell.^{30}.

March 13.—There has been constant improvement, and wound is entirely healed. One dose of Bell.^{30} given daily until

April 7.—Patient discharged cured.

Amputation of Hand.—Mr. W., æt. 27. Admitted to hospital May 30th, 1886. One week prior to his admission to the hospital,

while at work in the mill, his hand was caught between two pieces of sheet iron, causing severe laceration of the hand with comminuted fracture of the phalanges. Owing to the neglect on the part of the attending surgeon, gangrene had taken place, involving the fingers, and was rapidly extending through the hand, which, with the arm and forearm, was enormously swollen and extremely painful. The hand was amputated through the continuity of the metacarpal bones, making an anterior and posterior flap. A drainage tube was inserted, and the flaps united with carbolized silk sutures —wound dressed with iodoform and anti-septic gauze. Hot compresses of hamamelis were applied to the arm, and continued until the swelling was reduced.

Third day the dressings were removed. The discharge was healthy, and the wound looked well; dressings continued the same. Wound to be irrigated with a 2 per cent. solution of carbolic acid, morning and night.

On the seventh day, the drainage tube was removed, and a seton of horse hair inserted in its place. The discharge was very profuse, wound looked healthy and dressing continued the same.

June 10.—A portion of the seton removed. The wound is looking healthy, and the discharge gradually diminishing.

June 26.—Sutures and seton removed. The discharge is very slight and wound is healing rapidly. Internal treatment consisted of Arsenicum^{3x} followed by Hepar s.^{3x} when suppuration set in. Later an occasional dose of Chin. ars.^{3x}

July 10.—Patient discharged cured.

Rupture of the tendon of the quadriceps extensor (*right and left.*)—Robert McG., æt. 38, colored, admitted to the Homœopathic Hospital, March 16th, 1886. Two days ago, in stepping over an iron grating covering a sewer, he slipped, falling on his right knee causing a rupture of the quadriceps extensor and taking with it a small fragment of the upper border of the patella. In his attempt to save himself from falling, the left leg was so forcibly extended as to cause an injury similar to that of the right, except that the rupture was above the patella, that bone remaining uninjured. The patient says the snapping of the tendon caused a report like the firing of a pistol.

Dr. Willard was called but seeing the futility of any attempt to

treat him in his present surroundings had him removed to the hospital. The patient was anæsthetized, posterior splints applied and the foot of the bed elevated.

March 20.—Consultation of the surgical staff. Patient was anæsthetized, and by means of a curved needle about six inches in length a heavy silver wire was introduced subcutaneously, starting at a point opposite the joint, first upward, then transversly through the ruptured tendon, then downwards and through the integument just opposite the point of insertion. The two ends were then united. A strip of adhesive plaster was passed through the loop, and brought tightly under the sole of the foot, thus bringing the end of the ruptured tendon in close apposition with the patella. A posterior straight splint, well padded, was applied, which completely immobilized the leg and thigh, and raised the foot about twelve inches, after the method adopted by Hamilton for treatment of fracture of the patella. The right leg was then treated in a similar manner.

The limbs were allowed to remain undisturbed until the ninth day, when the bandage was cut and the knee examined. The parts were found to be in close apposition, and splints were reapplied with a many tailed bandage.

April 18.—The right leg was taken from the incline and the dressings and wire removed. A plaster of Paris cast was applied. Two days later the left leg was treated in the same manner. No inconvenience has been felt from the silver wire. He was allowed to sit up for a short time this afternoon.

April 27.—Casts were removed and the legs bathed and manipulated. The patella was firmly strapped with a *Fig. 8*, and the casts reapplied with a many tailed bandage. Union seems to have taken place.

May 9.—The casts have been removed and the legs are manipulated daily. Will be allowed to remain off during the day and reapplied at night.

June 7.—Patient walked across the ward for the first time today. All dressings removed and the patient allowed a limited amount of exercise daily. At no time has the temperature or pulse been above normal. The remedies used were Aconite, Bell. and Pulsatilla.

June 29.—Patient discharged cured.

Sept. 14.—I met him sitting on a jagger wagon; as I come along he wags his leg at me and remarks, "The cane you presented me on leaving the hospital I have directed to be buried in the coffin with me as I have no more use for it;" and, strange to say, this colored man says he loves me.

RESECTION OF THE KNEE JOINT COMPLICATED WITH CHOREA.

BY L. H. WILLARD, M. D., ALLEGHENY CITY.

CASE.—Viney McElroy, æt. 11 years. History of the case prior to admission to the hospital is very meagre. When a child, two years of age, she received a severe injury to the knee from a fall down a flight of stairs. This was neglected, receiving no attention, and resulted in anchylosis of the joint with the leg flexed on the thigh at a right angle. The family being in indigent circumstances, and symptoms of chorea which developed about the seventh year incapacitating the child for work of any kind, she was sent to the city poor farm where she remained until her admission to the hospital Oct. 10, 1885. At this time her condition was as above stated, the knee anchylosed and chorea chiefly affecting the right side. She was given a good nourishing diet, frequent bathing, with massage and ℞ Sulphur^{6x}, followed by Cuprum acet.^{6x} At the end of two weeks, the symptoms of chorea had almost entirely disappeared.

Oct. 23.—Patient was anæsthetized, and an attempt made to straighten the leg by boring through the joint with a drill followed by forcible extension. Failing in this a curved incision was made, with convexity downwards, exposing the joint. A V-shaped section including the patella and the end of the tibia and femur was removed, the limb straightened and the ends of the two bones brought in close apposition. The wound was filled with iodoform, a drainage tube inserted, the flaps united by wire sutures, and the leg dressed on a straight splint. ℞ Arnica^{3x}.

Oct. 24.—Temperature, A. M., 100°. P. M., 100.4°. Slept but little during the night, was very restless, and suffered considerable pain. Morphia, in $\frac{1}{16}$ gr. doses, was given at intervals; dressings were not disturbed.

Oct. 25.—Temperature, A. M., 102.3°. P. M., 103.2°. Is very restless, passed an uncomfortable night, suffering intense pain at times, which was controlled only by the administration of morphia. ℞ Aconite^{3x} every hour.

Oct. 26.—Temperature, A. M., 102°. P. M., 102.5°. The dressings were removed, and the wound found looking clean and healthy. Iodoform was dusted freely into wound and over the surface. A sponge wet in a two per cent. solution of carbolic acid was applied, the whole covered with absorbent cotton, and retained with a many tailed bandage. The splint was not disturbed. Aconite continued.

Oct. 28.—Temperature, 101.2° in A. M. 103° at 6 P. M. Wound looking very well. No discharge. Was dressed as before. ℞ Acon.

Oct. 29.—Temperature, A. M. 100.3°. P. M., 103.1°. The discharge was very slight; wound was irrigated with a two per cent. solution of carbolic acid, and dressed with iodoform. ℞ Arsenicum^{3x} every three hours.

Oct. 30.—Discharge from the wound is more profuse. Wound was irrigated with carbolic acid solution and dressed as before. Temperature, A. M., 100.3°. P. M. 101.2°.

Nov. 1.—There is a very profuse discharge of laudable pus from the wound, and the leg is very painful. Symptoms of chorea, which had almost entirely disappeared at time of operation, are greatly aggravated, so that it is impossible to keep the leg in any one position. Dressings were applied as usual. Temperature, A. M., 99.2°. P. M., 100°.

Nov. 3.—The flaps, which at first seemed to be almost entirely united, are separating, owing to the chorea which keeps the limb in constant motion. The anterior edge of the end of the femur has also cut its way through the skin and is exposed to view. The discharge of pus is very profuse. The swelling of the limb is somewhat reduced so that the primary dressing is slightly loosened. Patient was anæsthetized and the dressings, including the long

splint, were removed and reapplied. Temperature, A. M., 99°. P. M., 101.4°.

Nov. 5.—The discharge of pus is *very* profuse. There is great restlessness and almost total loss of appetite. Chorea greatly aggravated. A consultation of the surgical staff of the Hospital was called to decide the advisability of an amputation which appears almost unavoidable. It was deemed best to postpone any operation for a few days at least, and Rhus tox.^{3x}, every two hours, was prescribed.

Nov. 7.—No perceptible change in condition. The discharge from the wound is very profuse, but pus is laudable. Temperature, A. M., 99°. P. M., 101°. Treatment same continued.

Nov. 10.—Temperature, A. M., 98.5°. P. M., 101.5°. Union of the flaps is beginning to take place again. Granulations appear healthy. The discharge from wound continues very profuse. ℞ same.

Nov. 13.—The discharge is somewhat less to-day; pain not so intense. Patient is resting more comfortably, and her appetite is improving. The symptoms of chorea, too, are becoming less marked as the general condition improves. Dressings continued as before. ℞ Chin. ars.^{3x}.

Nov. 15.—The discharge from the wound is still quite profuse, but is daily growing less. Patient is very comfortable, sleeps well, and suffers but little pain. Wound dressed with iodoform and oakum. ℞ same.

Nov. 20.—Gradual and continued improvement.

Nov. 23.—The patient was anæsthetized, the dressings removed, and a plaster of Paris splint was applied, extending from the ankle to the thigh, with fenestra at the knee through which the wound is dressed. The soft parts are healing nicely and firm union of the bones seems to have taken place. Treatment continued same.

Nov. 28.—Condition is improving daily. The discharge from the wound is diminishing, and the soft parts are healing rapidly. A small sequestrum of bone, from the end of the femur, came away to-day. Wound was dressed as before and remedy continued.

Dec. 1.—There is a constant improvement in general condition of the patient, and the symptoms of chorea have almost entirely

disappeared. She eats and sleeps well, and the appearance of the wound grows better every day.

Dec. 15.—Another small spicula of bone, from the end of the femur, was removed to-day. The wound, as well as the patient's general health, continues to grow better daily. Treatment continued.

Dec. 31.—The plaster of Paris splint was removed to-day. Bony union is very firm, and the external wound is looking very healthy. The discharge is slight and daily growing less.

Jan. 6, 1886.—The patient is allowed to walk about the ward with crutches. Her condition continues to improve slowly.

Jan. 10.—A posterior splint of binder's board was applied to give support to the knee. The discharge still continues, but is very slight. The wound has almost entirely healed, swelling has subsided, and there is entire freedom from pain.

Jan. 18.—A slight aggravation of symptoms to-day, produced by a small spicula of bone, which was removed. The wound irrigated with twenty per cent. solution of iodine, and dressed with iodoform cerate.

Feb. 9.—With the exception of a slight discharge from the knee, the patient appears to be perfectly well. This discharge is gradually growing less as the patient grows stronger. ℞ Calc. phos.^{6x}.

April. 1.—The discharge from the wound has become so slight as to be hardly noticeable. Patient can bear her entire weight on the leg without any unpleasant symptoms. Dressing changed to plain cosmoline and lint. ℞ continued.

June 1.—Wound is entirely healed. There is no discharge, and patient can walk about with no inconvenience other than results from the stiff joint and the difference in the length of the limbs, about two and one half inches.

June 29.—A splint, made of two strips of steel, to give support to the knee, and an elevated shoe have been applied, and give excellent result. Patient is able to walk about with but slight inconvenience.

August 3.—Discharged, cured.

DISCUSSION.

Dr. J. H. McClelland called particular attention to the case of rupture of the quadriceps extensor tendon mentioned by Dr. Childs. The main point of interest in the case was the fact that the patient could stand wire suture in the tendon for six weeks without bad results.

Dr. B. W. James observed that the results in many cases depended upon the temperament of the person operated upon.

Dr. J. H. McClelland said that he thought the paper on supra-pubic lithotomy made a good showing, one that the Society ought to be proud of. The third case reported occurred in Pittsburgh. There was one point in the case that seemed to be involved in doubt, and that was in relation to the primary union of the wound in the bladder. The discharge from the wound was described as a serous discharge, which would seem to indicate that the supposed primary union did not occur. In order to clear up this point, Dr. McClelland stated the following facts in relation to the case. The discharge continued without reference to the amount of urine or fluid contained in the bladder. The urine drawn from the bladder was powerfully ammoniacal, the fluid that flowed from the wound was absolutely without odor. Then, too, it was found, on testing, not to be urine, but serum; so there could be no doubt as to the primary union of the bladder wound in this case. That has taken place in other cases, so that perhaps its occurrence here is not so remarkable, but the rule is for the bladder wound not to adhere primarily.

Dr. W. B. Van Lennep said that the incision, as usually made in supra-pubic lithotomy, was too small. He was opposed to tearing through the tissues as recommended by many eminent men. He did not think that a wound of the peritoneum should be feared. If united by a stitch or two, healing will take place in twelve hours. The main danger in the operation is the infiltration of the connective tissues with urine.

THE REPORT OF THE BUREAU OF PATHOLOGY Was next called for. The only paper presented was:

The Pathology of Croupous Pseudo-Membranes, by John C. Morgan, M. D., of Philadelphia.

THE PATHOLOGY OF CROUPOUS PSEUDO-MEMBRANES.

BY JOHN C. MORGAN, M. D., PHILADELPHIA.

There are general resemblances between pseudo-membranous formations, wherever found; yet diversity of subjacent and contiguous tissues gives rise to characteristic differences, while the diverse functions of the parts involved widely separate them with regard to clinical symptoms and results. Fibrinous exudation, containing living leucocytes, which mostly die, becoming pus globules sooner or later, is the leading feature, when acute. When chronic, other conditions prevail, which are in their nature mainly cicatricial, sometimes ulcerative; for instance, within the uterine and rectal cavities. The general appellation of these is, "croupous membranes," and the attendant inflammation "croupous inflammation." The pseudo-membranes of mucous surfaces will be here mainly discussed, with the reasons and causes of such formations. The preliminary thought in all is, that a croupous formation is not the simple phenomenon of exudation, which it is often supposed to be, but is a complex fact requiring careful analytical study for its comprehension, and also for its proper treatment, since a false method must inevitably tend to failure and often to death. The first maxim in medicine should be to do no harm, and we look chiefly to pathology to guide us in its fulfilment. Positive therapeutics is a more remote problem, where Hahnemann becomes master.

We will first briefly consider what may be *seen*, in gross and under the microscope. The gross appearance is that of a membrane, in masses of various size and shape, moulded by the containing organ, of divers tints, from grayish white to yellowish, sometimes bloody at the surfaces of separation. I shall here ask attention to the microscopical examination of two cases of my own, made with simple "teasing" of the membranous product, pressure

under the cover-glass, and observation with a quarter-inch objective, and eyepieces Nos. 1 and 2; one, of membranous expectoration of subacute croup; one, of chronic membranous dysmenorrhœa; and one, of chronic membranous dysentery.

Case I.—L. S., a little girl seven years old, had a catarrh of the respiratory passages during several weeks, croup supervening, and finally proving fatal, despite the evacuation, with muco-purulent catarrh, of much of the pseudo-membrane, in chunky pieces, during many days.

A fragment of this product, being teased into a thin layer, and examined, showed only fibres, closely interlaced, and inclosing myriads of leucocytes, otherwise called white blood globules, emigrants from the congested blood vessels of the air-tubes, and now known to us as "pus corpuscles," all of which names, however, as now known, are held to mean one and the same thing, differing only in numbers and in circumstances. Only a few epithelial cells were found, mostly isolated.

Case II.—Mrs. B., æt. 40 years, from whom I removed a mucous polypus, several years previous had had, since her last confinement, some ten years before, subinvolution of the uterus, with menorrhagia, and very painful periods; and during the intervals, great inflammatory soreness, and on examination with the speculum, livid redness of the uterus and vagina, hyperplastic enlargement of the former, and a foul, gray, purulent, irritating leucorrhœa.

In my judgment, every such case is to be suspected of a croupous or membranous nature, and she was, therefore, instructed to save everything evacuated at the next menstrual period. I found therein a complete cast of the corpus uteri, the pseudo-membranous quality of which was easily proved, to the disgust and even alarm of the patient. It was internally smooth, externally shaggy. The microscopical examination showed, of course, an abundance of red blood globules, in and around the membranous material; the latter was composed of fibres of coagulated fibrine, inclosing numerous leucocytes, or, we will say, globules.

In both of my cases, from the respiratory and the uterine mucous membrane, the structure of the morbid product was the same, composed essentially of fibres and pus-cells; with red blood globules, when connected with menstruation. In none was the mu-

cous membrane itself examined; in all, therefore, the separated product only was observed. The lack, however, is well supplied by other investigators, who have made thin sections of the diseased parts—post-mortem—extending from healthy tissues, to and through the lesions, including all the transitional elements, enabling us to clearly perceive the steps of the morbid changes in the organs themselves, as well as the nature of the adventitious substance.

This membrane constitutes the objective point of all empirical treatment, and in pseudo-membranous, occasions all the alarm croup of the trachea it is described by Wagner (*Gen. Path.*, page 263), under the name "croup membrane," and he states that it "shows a remarkably great resistance to heat and all chemical reagents" (rather discouraging news for the empirics).

This "croup membrane" closely resembles all fibrinous exudations, but its peculiarity is that it is not a mere pouring out of fibrine and leucocytes upon the free surface of the mucous epithelium; but it "has its origin in a peculiar metamorphosis of the epithelium" itself"; so that it *takes the place* of the epithelium, which is there partially wanting in consequence.

In the *normal* processes of epithelial nutrition and metamorphosis, the cells are rapidly formed, and soon die by change into mucus proper, developing the albuminoid principle called *mucin;* new or young cells, however, being first formed, to take the place of those about to be thus degenerated, metamorphosed, or dissolved. This normal change of the epithelial cells is called mucous degeneration, or rather, "mucous metamorphosis."

When, however, croup membrane is formed, this normal change of the cells is supplanted by a totally different one; this mucous degeneration and solution, and the reproduction of young epithelial cells, both cease, and a new and morbid change occurs in them, called "croupous metamorphosis," whilst beneath this the basement tissue becomes practically little less than an ulcer. Thus, the origin and character of the lesions, in the several localities whose product I examined, and in all such cases become clear, viz.: superficial ulceration, covered with metamorphosed epithelium, destitute of life and of cellular structure, but, as a fibrino-purulent cover, adhering to the ulcerated surface. How it can be separated

and how a normal epithelium can be restored, is then the question; but some other points must be first considered, viz.: the mode of development and the progressive microscopic appearances of this croupous metamorphosis of the epithelium, together with the etiology of this process.

According to Wagner, it shows, in the first place, an increase of quantity in the protoplasm of the epithelial cells, with a consequent enlargement of them. Next, there appear in the protoplasm minute coagulations, at many points, $\frac{1}{100}$ of a millimetre, or less, in size, and as they increase in number they advance from the periphery towards the centre of the cell. The effort at normal young cell formation is occasionally still seen also in the enlargement and division of the nucleus, as is usual in health.

Between these points of intra-cellular coagulation, the remaining liquid protoplasm of the cells is seen, brighter or darker, according to the direction of the light falling upon it, and the general effect is to give such cells a porous or indented look; and it is now that they become, as previously intimated, "strikingly resistant."

This change in the cells goes on, however, until the last of the liquid protoplasm disappears; the cell-wall is contracted irregularly, forming pores, and toothed outlines, fusing with those of adjacent cells, these being, however, artificially separable, as by maceration of the membrane in "Müller's fluid." This being effected, the process, in all its stages, can be studied in the separated elements, each showing its own degree of the metamorphosis called "croupous." During its progress, of course, the nuclei gradually disappear. Still, others of these cells are invaded by emigrated white blood globules, and these become pus-cells, to the number, sometimes, of half a dozen in a single one of the epithelial elements.

Such is croupous metamorphosis, and such is the origin of the dense, resistant, fibrino-puruloid pseudo-membrane with which we have to do. As before said, however, and notwithstanding this demonstrated mode of development within the individual cells, the *completed* membrane, in gross, and even by microscopic examination *without* the artificial cell separation just described, cannot be distinguished from any ordinary fibrinous exudation, with its usual

fibrillation, with its entanglement of white cells, and of the serum of the blood. By way of emphasis, I will quote Wagner again: "Croupous exudation, on account of its similarity with fibrinous exudation, is in many ways confounded with it, but, from its nature and origin, is entirely distinct from it"; yet he says, repeatedly, it "resembles coagulated fibrine," as I have myself, also, demonstrated above; and we may, therefore, fancy, at least, that, after all, the protoplasm of the altered cells has itself gradually undergone a *change to fibrinous fluid*, in order to suffer such a metamorphosis. At all events, all clinical considerations must begin by recognizing the *cellular origin* of all croupous pseudo-membranes, and the folly of treating it as a mere fibrinous effusion upon a free surface, must be now evident.

Diphtheria furnishes a pseudo-membrane, very similar to other croupous membranes, but produces also an *interstitial* deposit, the so-called "pure diphtheritic exudation," to wit, an infiltration of the mucous membrane and subjacent tissues with white globules, and particularly with free nuclei, tending to strangulation and sloughing. Indeed, this infiltration is widely extended in the body generally, in the viscera, etc., doubtless causing general toxic effects. In addition, the micrococcus, the microbe of so many low morbid states, and even of some healthy organs, as the mouth, throat, etc., is found in the superficial strata of the membrane, as well as in internal parts. Still farther, according to Lœffler's recent researches, occur the peculiar bacilli observed by Klebs and himself, and which he regards as the only *specific* microbe of diphtheria. It is found in the deeper strata of the pseudo-membrane.

The very latest portion only of this product that is found immediately overlying the engorged vessels, in fatal cases, and probably deposited subsequent to the true croupous metamorphosis of all the epithelium, consists of diffuse fibrinous exudation, pure and simple, according to the same authority.

These traits distinguish diphtheria from simple "membranous croup" of the larynx, trachea, &c.; the frequent albuminuria, and the systemic infection are also wanting in the latter. Finally, it should be remembered that pure croup, according to Wagner, presents, in the greater number of fatal cases, an extension of

membrane upwards to the soft palate (recalling the key note of *Bromine*, false membrane extending upwards from the larynx), together with muco-purulent catarrh of the bronchi.

En passant, it must be noted that not all pseudo-membranes are croupous. Thus ulcers of the intestines, having no epithelium, may have passed beyond the possibility of that metamorphosis, yet produce a fibrinous exudation, entangling cells and other *debris*, as shown under the microscope.

Returning to the purely croupous pseudo-membranes, we are led to ask why the epithelial cells of all or any of the mucous membranes, not alone the respiratory, should ever suffer the characteristic fibrine-like metamorphosis of their protoplasm, above described. This etiological question bears on that of a reasonable therapy.

We may, in seeking a reply, interrogate the blood-vessels, the blood itself, and the forces of the circulation ; also the lymphatics, the nerves, etc.

First, the *blood vessels*. These, in the initial inflammation, are, of course, arterially and actively distended. Later, and along with the diminution of the fever heat, as in all other active diseases, the minute veins show a greater participation, as we find illustrated in conjunctivitis, and in pharyngitis, the color becoming darker. Coincidently, all sorts of exudation more easily occur, through their mechanical distension, and so we have swelling.

Second, the *blood itself*. Here we find great possibilities as to fibrinous formations. The reaction of normal blood is decidedly *alkaline;* yet, from what we know of the action of the liver upon digested starch and sugar, producing glycogen, or animal dextrine, which goes everywhere with the blood; and remembering that the mere splitting of a molecule of glycogen produces two molecules of lactic acid; that this is a normal result of muscular irritation, as in normal activity, partial alteration of the blood in this respect is not surprising with the conditions existing, during active disease. Rheumatic hepatitis likewise seems capably of it. It is certain that alkalinity opposes fibrinous coagulation, whilst acidity, however slight, tends to promote it. Since, according to Brown—Sequard, fibrine is also a special product of muscular

activity, this body may be chemically affected at its very source, or in patients who are abnormally active.

In still another particular, may the blood itself contribute to fibrinous metamorphosis. Polli and Virchow have shown that fibrine, in the lymph, exists in a form which does not readily and spontaneously coagulate and even when this does not take place, the clot is soft and diffluent. In the blood, a part of the fibrine normally exists in the same form, and has been distinguished by Denis, by the name of "dissolved fibrine," this does not, when removed from the body, spontaneously coagulate, but adding the Epsom salt—the sulphate of magnesia—causes it to do so. Thus, without the presence of any free acid at all, lactic or other, we find that the introduction of a *saline* substance is capable of promoting the fibrinous metamorphosis. That this particular salt may, therefore, be pathologically homœopathic to this process, will, of course, occur to every one in our ranks, upon the mere mention of it. Tests are, however, yet lacking.

The remainder of the fibrine is spontaneously coagulable when at rest, when exposed to the air, or when mechanically entangled; and this is called, by way of distinction, "concrete fibrine." The two forms, as combined in the blood, form a total within the body, called by Denis and Schmidt, *plasmine*, in opposition to all the other albuminoid matter of the blood liquor, which receives the name, *serine*. This double fibrine is, furthermore, *wholly* coagulated by an excess of chloride of sodium. In croupous pneumonia, and other acute diseases, as all know, there is a disappearance of chlorides from the urine, whilst there is increase of the same in the expectoration. How far this local accumulation of the chlorides may promote the croupous metamorphosis, is certainly worthy of thought.

These facts, also, raise the same question as arose in reference to the magnesium sulphate, viz: Is the sodium chloride pathologically homœopathic to croupous diseases?

It may be objected that all these are "too similar" that is, that they are "identical," and hence not truly homœopathic. If so, a sufficient variation may be found, perhaps, as to the sodium salt, in the bromide, or the iodide, or the bicarbonate, which is, besides not without a record of empirical success in pseudo-membranous

croup, or the biborate, likewise valued in membranous dysmenorrhœa, or if we think of a potassium chloride, the Kali carb, which has done good work in both maladies, or Kali caust., which has also done something. Of the magnesium salts, the soluble citrate may be worthy of particular consideration; and as to lactic acid, its sodium and potassium salts may be mentioned—uniting the indications for these bases with its own, that is, if they do not materially subvert each other. The ammonium salts also deserve a good word. Again, if the sulphuric acid of the magnesium sulphate, and not the base, be thought of as the coagulant, then its sodium, lime and potassium salts may be found suitable. The latter two find place in Schüssler's croup system. All of which, however, in the view of a sound and conservative homœopathy, must await the proof to be furnished by experiments upon healthy human bodies. And we are obliged, of course, to extend the same query to lactic acid, for the same reasons first given.

Whatever in medicine, or diet, or muscular exercise or irritation, can cause the accumulation of either of these bodies in the blood*, should be regarded with suspicion, lest it prove a dangerous factor of fibrinous, and of croupous diseases, simple or diphtheritic, acute or chronic, tracheal or uterine, etc., (and possibly, in that other and fatal affection, heart-clot).

Third, the *blood momentum* has normally, a large share in preserving the fibrinous principles in fluid form, and also in preventing exudation, thus in two ways, opposing pseudo-membranous formations. Everything which in the least degree diminishes the force of the circulation, therefore—even the obstruction produced by spasmodic croup—may be of grave significance, and for this same reason, a too rapid cessation of fever is most undesirable also, and may often be a legitimate ground for apprehension, whilst a sudden weakening of the heart by materialistic doses of Aconite or Veratrum vir., may prove lethal in this way.

Any loss of arterial force—arterial obstruction, in particular—has a tendency, also, wherever arterial *anastomosis* is anatomically deficient, as in the spleen, and in the cortex of the brain, in operations after ligating every vessel, to promote hæmorrhage, and often, surprisingly soon, of which the result is often, in spleen or brain, an

*See Burnett on "Supersalinity of the Blood."

apopletic blood-clot, called in the former organ a "hæmorrhagic infarction." This is explained by the known violent reflux of the venous blood, whenever and wherever the arterial *vis a tergo*, both direct and anastomotic, happens to be withdrawn. There is an added possibility in all diseases where antiphlogistic measures are abusively pushed. It is also a fair question whether a like effect may not occur, without extravasation, at all, of red blood globules; that is, with fibrinous globules, not globule hæmorrhage. The significance of this mechanical agency, however, I would expect to appear more in the corporeal uterine circulation than in the tracheal; and in the chronic membranous dysmenorrhœa, as well as in the acute forms, the arterial system of the womb being greatly isolated, like a segment of the spleen.

Fourth, and coincidently, deficiency of (blood and body) heat, as after the subsidence of a high fever, may help on the degeneration. Fever, if moderate, is oftimes conservative.

Fifth, the function of the lymphatic system in relation to pseudo-membranes is sometimes very conspicuous. In diphtheria, the glandular swellings sometimes become enormous—a point of distinction from simple membranous croup. Still, even in the latter, this system cannot play an indifferent part, as its subjacent relations with both the epithelium and the capillaries show.

Both the blood vessels and the lymphatics have an ultimate structure of connective tissue, and their endothelial lining consists simply of flattened and oblong connective tissue cells. In the capillaries, these cells are disposed with their edges closely together, only excepting points where their individual outline is incomplete, and it is, at these incomplete points, clearly visible under the microscope only when the vessel is distended, that the emigration of white blood globules from the blood-vessels is so easily observed. The excess of blood-liquor, containing the fibrine excrement of the tissues also escapes, and all these are at once carried off by the lymphatics, if not disabled, but are detained in situ, if the channels be impaired.

The beginnings of the lymphatics are two-fold, and their endothelium is here always, so sparse as to form only spaces of connective tissue, not vessels, at all, until they have advanced somewhat towards the common centre, when the vessels become perfect

and are completely lined, like the blood-vessels with endothelial cells. Thus their beginnings are admirably adapted to the absorption of all exudations. These beginnings are: 1, just beneath the mucous capillaries, to which they thus form a half-sheath, the mucous epithelial cells forming the roof of the same; and, 2, minute extensions of these lymphatic spaces, reaching up between the capillaries, touch the under surfaces of the epithelial cells of the mucous membrane. The lower half-sheath of the capillaries formed by these lymphatic or connective tissue spaces, are now seen to surround the individual blood-vessels, and are, therefore, called "perivascular spaces." In the brain, they envelope the whole vessel, and are regarded as of great importance. In the mucous membrane, they cannot be unimportant, particularly as to a proper *drainage* of the tissues. Every superficial or deep swelling depends very much upon the filling up of the lymphatic or connective tissue spaces.

Inflammation, as in croup, causes excessive accumulation of the materials poured out above and below the vessels, and the perivascular lymph-spaces have, in their own way, as much to contend with as the mucous epithelium. Failing to remove all these accumulations, swelling, obstruction and stasis result—drainage is incomplete—fibrine-excrement remains in the tissues, with venosity from pressure, also, to confuse their nutrition. At the same time, the extension of the inflammation to the connective tissue itself must, by multiplying its own cells, exaggerate this obstructive interference. According to Wagner, the lymphatics, in inflammation, are either dilated and filled with these products, viz.: "pus, fat, detritus," and occasionally, with fibrinous coagula; or, on the other hand, owing to the outside compression, the lymphatics have often been found progressively collapsed, the lymph stream becoming slower and slower, and then ceasing entirely; tissue drainage in that direction ceasing also. Simultaneously, the distended venous capillaries cease to do their part as absorbents, whilst the secretory cells fail to do theirs, in the proper metamorphosis and final evacuation of the materials brought to them.

Sixth, the venous system must be included among the factors of croupous metamorphosis. I will not retread this well-beaten track to any great extent, but only remind you that it is foremost in

causing spasmodic symptoms, not only in tracheal croup, but in membranous dysmenorrhœa, dysentery, etc.; and, besides this, that in all cell-life, of which these are abnormal illustrations, the trophic, or tissue-formative nerves, have an undoubted function. A familiar instance is seen in ulcerations of the cornea, due to paresis of the ciliary nerves. That a like paresis, or some other perversion of the tracheal or uterine or other trophic nerves may contribute to the croupous metamorphosis, by negation, at least, of their normal preventive activity, is more than likely. Excessive medication is naturally hurtful in the presence of such paresis.

Seventh, and lastly, the cell-life itself, in abnormal action, or inaction, is obviously the nearest of all the facts in causation of the croupous metamorphosis. Why should the living cells, which normally resist and resent all intrusion of improper materials, and assure the elaboration of normal products only, fail, in so grave a manner, to perform these duties? There are two parts to the reply: on the one hand, we must say that all the above-named causes of abnormal pabulum may co-operate to *overwhelm* their normal conservatism; and, on the other hand, their own dynamic conditions may be defective—and this, in several ways; by constitutional taint, inherited or acquired, or by paresis of the trophic nerves, as just mentioned; through either or both of these agencies, the elective matter-exchanges, which are their chief function, cease to be effected, and they can thus become the passive victims of even the ordinary access of the blood-liquor, fibrine and all.

Put all these possibilities and facts together, and we may the more intelligently give answer to the final question: What is the *natural history* of croupous pseudo-membranes?

Recall, if you please, what was first said as to the formation within the affected epithelial cells, of minute opaque particles at the periphery, where the fibrinoid alteration first takes place, and how this may be proved by macerating the tissues in Müller's fluid, whereby the elements are caused to fall apart, and may be separately studied in every stage of the change; and how this formation gradually advances to the centre of the cell, obscuring the nucleus, and finally replacing all the ordinary or normal protoplasm which it previously contained. Then, compare this with the normal procedures, and thus learn what has to take place, in

either the acute or the chronic form, before the mucous membrane can return to a state of health.

Normally, the epithelial cells continuously and also rapidly grow, multiply, die and disappear. They mature and then undergo the "mucous metamorphosis;" in other words, they become chemically transformed, particularly as to their protoplasm, into a new form of albuminoid body, called mucus, the basis of which is *mucin.* Thus they are successively liquefied, and mingled with cast-off individual epithelia, and with emigrated white globules, here called "mucous corpuscles"; and, thereafter, the whole is disposed of as the ordinary secretion of the part.

Now, the croupous ruin of even the superficial epithelia of a given space must be separated by the interference of the subjacent and youngest cells, which, having thus far escaped the process, are still vital and active, the part undergoing a kind of cicatrization indeed, very much like healing under a scab.

The croupous cells, however, being virtually necrosed, a more extreme involvement, extending to the deeper layers, removes the barrier to free emigration of white blood globules (leucocytes) from the distended vessels; consequently, these are copiously effused from the vessels, depleting them and promoting their restoration. The white globules themselves become pus-cells; and, in short, there is now suppuration beneath the croupous epithelium, which duly separates as a slough, sometimes *en masse*, sometimes piecemeal.

At the same time, every remaining normal cell in the deepest layers, and in the surrounding region, being stimulated by the neighboring inflammation, is growing, multiplying, forming mucus, and thus helping to undermine and cast off the pseudo-membrane, and to reform the normal tissue.

What can Nature do, in this corrective process? Nature can and must do everything, and will, if we but content ourselves with *aiding her in these processes*, and avoiding impatient and impertinent interference with her, by over-drugging and by other excesses, which can only aggravate. Croupous pneumonia, once believed to be incurable, without the most heroic measures of depletion, counter-irritation, expectorants, anodynes, etc., is now known to be, when simply reversed, *self-limited.* What a thought for the

doctor about to lose his head in the presence of a case of croupous laryngo-tracheitis!

Certain observations at the seashore during the past summer, have inspired the query with me, are not the majority of fatal cases of the latter disease actually killed by kindly meant heroic doctoring. One little girl I saw, with the red cicatrix of a laryngotomy done in June last, and after only twenty-four hours of allopathic medication. I could not refrain from believing, as I still do, that nothing but the drugs and other active and aggravating expedients used made the operation necessary. Just at this time, I was called to a precisely similar case, to which Dr. J. R. Tantum, of Wilmington, Delaware, was also a witness. The child recovered gradually, quietly and perfectly, within three weeks, after very conservative homœopathic medication, based upon the reflection that the other case got well when her physician had doubtless, after opening the larynx, recovered his senses sufficiently to suspend active measures, and to reasonably depend on nature for the resolution of the inflammation, and the normal separation of the pseudo-membrane. In my own case, this separation was duly announced by a choking and swallowing spell, followed by entire and permanent abolition of all signs of croup. The only remedies used, aside from two doses of Cham. which acted adversely, were the three "old stagers," given as Hahnemann would give them, viz: Aconite in the fifteenth centesimal dilution, Spongia^{200}, and Hepar sulphuris^{200}. There may be no drug substance beyond the eleventh centesimal dilution. This is a pathological, not a clinical paper, and I submit to that decision if you will, but thereby I must strongly emphasize one more question, viz: Is not acute membranous croup normally self-limited?

The chronic forms, I am sure, are subject to parallel reasoning, only remembering that Hahnemann has taught us that all chronic diseases are such by virtue of an added factor, opposing the natural tendency to health, viz: some chronic miasm; to the reality of which, as I have argued elsewhere, modern pathology has given weighty testimony.

As to the bearing of the foregoing remarks, "croupous pneumonia," and upon that form of Bright's disease known as "croupous nephritis," no detailed discussion can be indulged in at this

time, and this paper would be thereby unjustifiably extended. That question may, however, be raised with propriety, in closing, and left for the reflection of thinking physicians.

THE REPORT OF THE BUREAU OF SANITARY SCIENCE

Was next presented. The only paper belonging to this bureau was

Cremation, by Sarah J. Coe, M. D., Wilkes-barre.

CREMATION.

BY SARAH J. COE, M. D., WILKES-BARRE.

Cremation or burning of the dead is a most ancient practice. Some authors ascribe its origin to the Sun-worship of the Phœnicians, while others think it was derived from the self-immolation of Hercules. Dr. LeMoyne asserted that the first authenticated case of cremation was the proposed incineration of Isaac, and that, although it was not consummated, it was fully authorized by the Deity. In consequence, he argues that cremationists stand in the shadow of the Lord, and that any one that opposes them commits a sacrilege.

The relics of the bronze age in Great Britain and Denmark show that it was used in that period, and its prevalence among the ancient Britons is known from history. From the earliest times, it was practiced among several other Western nations, and among the people of Eastern Asia. It was general among the ancient Greeks, and must have been adopted by them at a very remote period.

Numerous instances of cremation are described in Homer's poems and in Virgil's "Ænead," as occurring about the time of the Trojan war. It was borrowed by the Romans from the Greeks, and was not generally practiced among them till toward the end of he Republic.

The custom gradually went into disuse under the Empire and appears to have been abandoned about the end of the fourth century, but, Phœnix-like, it reappears with all the brilliant plumage which science can devise.

In America, Dr. Le Moyne's furnace was in use in 1876. In 1878, a crematory was constructed at Gotha in Saxony, and since then many others have come into use throughout the Old World. This month, the Parisians will be able to burn their dead in four crematory furnaces just finished at Pere La Claire. In the United States, we have twenty, or more, cremation societies, and some of these have furnaces already in use.

The mind of the thinking public has been, and continues to be, turned with anxiety to the subject of the *best sanitary measures*, because of its vast proportions and many phases.

The question of cremation is entirely a sanitary one, and thousands of earnest and intelligent men and women in our country, as well as in other countries, are considering this new method of the disposal of the dead, as a necessary reform, while others, with Dr. Hamilton, assert that it is not a necessary sanitary measure.

The friends and advocates of the reform are called heathen, cranks, and infidels, but they may console themselves with the remembrance that the Reformation of Luther was considered infidelity; the electricity bottled by Franklin as sorcery, while the funeral pyre, the suttee, the Moloch of old, bears no similarity to cremation, except in the fact that fire was the reducing agent.

In the progress of the world's development and advancement, the greater becomes the need of artificial interference with the process of nature. The moment that life parts with its earthly tenement, decomposition sets in, and the organic tissues are gradually converted into highly poisonous chemicals, and one of the greatest problems of civilization has been to reconcile this process of death with the conditions of healthy life.

Before cremation will become popular or be accepted by the larger class of people, prejudice, ignorance, and false education must all be overcome.

It is somewhat curious to note the grounds on which it has been opposed. Some have declared that the abandonment of inhumation would rob the earth of its due allotment of nitrogen.

The reply of the cremationist has been that while the nitrogen of the incinerated body passes into the atmosphere in a gaseous form, it is, by the rain, eventually deposited in the earth just as surely and effectually as if inhumation were practiced.

Another claims that "if practiced to any great extent, the vapors and gases given off, must poison the atmosphere and make widespread unsanitary conditions." To this, Prof. T. R. Baker, Ph.D., after making an analysis of thirty jars of gases collected from the escape-flue of the Lancaster Crematorium says, "not any of the many and various tests, either at the Crematorium, or in my laboratory, indicated the presence of anything that would pollute the air. The burning of the body produces no material difference in the gases escaping from the chimney. The volume of the chimney products did not seem to be increased by the burning of the body, and the products had precisely the same odor during cremation that they had before the body was put in the retort.

To the objection that cremation is unchristian, Canon Farrar says, "The martyrs were burned at the stake, and no question has ever been raised as to their resurrection and future life. We believe in the return of our bodies to the dust and ashes from which they came. Hence, why not carry out the inevitable in the most expeditious, most economic and healthful way possible?"

The Bishop of Manchester said, when consecrating a crematory, in 1884: "It is no more impossible for God to raise up a body at the resurrection, if needs be, out of the crematory particles *which had been liberated by the burning*, than it would be to raise up a body from the dust."

When all the facts and horrors connected with earth-burial are known, and placed in contrast with the objectionable history of scientific cremation, Christian people will no longer allow the misrepresentations of enemies to keep them from the better way.

Another argument brought against cremation is that it destroys the evidence of poisoning. This is met by the assertion that every crematory requires the certificates of two reputable physicians that the deceased died from natural causes. When the evidence is not satisfactory, a careful autopsy is held before incineration is permitted. Where vegetable poisoning is resorted to, the opportunity to discover the crime is just as good, if not better, for the vegetable

poisons soon decompose with the body. The mineral poisons can be detected as easily in the ashes after incineration as in the body before.

The *Weekly Medical Review* says: "If the custom of cremation was adopted, there would unquestionably be instituted a more searching investigation relative to the cause of death in cases which at present undergo little or no investigation, and such systematic investigation might contribute largely to the further development of pathology. It would give us hitherto unobtained information on the absolute amount of mineral salts contained in the human body at various ages, and their variation in different callings in different regions. In stone-cutters, for instance, we should expect quite an increased quantity of the mineral constituents peculiar to the stone on which the individual was accustomed to work, it would be found partly in the lungs and in part disseminated over the body. For, if small particles of coal can thus find their way through the lungs to distant organs, there is no reason why other small particles may not pass through similar channels. Accurate knowledge on these points would be peculiarly interesting as facts, and would be very likely to lead to eminently practical results."

We would, then, name as one of the practical advantages claimed for cremation, a further development of pathology.

Another argument in its favor, is that it hastens the natural process of decomposition.

The tendency, of late years, has been to use every means possible to retard decomposition. The body is subjected to the process of embalming, then enclosed in a metallic casket, and placed in a stone or brick-lined tomb, where the inevitable process of decay goes slowly on, poisoning the atmosphere, and causing a variety of evils that were unknown under the older and simpler methods of burial.

Loude regards "the gases that escape from tombs built of masonry, as more dangerous than any other emanation whatever, because having no opportunity to escape, they become highly concentrated and act with tremendous potency. He refers to a case that occurred at Dijon in 1713, in which the accidental breaking of a coffin that had been buried for six weeks, caused very severe diseases in one hundred and fourteen out of one hundred

and twenty persons who were present at the opening of the tomb and from which eighteen died.

Dr. Parkes, the eminent sanitarian, tells us "that each decomposing human body generates annually about fifty cubic feet of carbonic acid gas; that the atmosphere of thickly populated countries contains, ordinarily, more than double the normal proportion of carbonic acid gas and other deadly exhalations; that the atmosphere of burial grounds is freighted with the germs of almost every form of zymotic disease."

The germs of disease, like any other seed, may be dormant and unchanged for years, until happening, in favorable conditions, they germinate almost instantly into life.

When victims of yellow fever and cholera are buried, the germs may remain viable for an indefinite period, and as they are carried to the surface by worms, they become the source of contagion.

Dr. Friere, in his investigations of the cause of yellow fever in Rio Janeiro, found the soil of cemeteries in which its victims had been interred absolutely filled with micro-organisms, identical with those found in the vomit and blood of his patients who had died with it. Hence he characterizes those cemeteries as the nurseries of disease.

Le Ver, in the *Progressive Age*, says: It is estimated that five times as many cases of cancer occur in New York and in the New England States as are found west of the Mississippi among the same number of inhabitants, and there is a much larger ratio in regard to consumption. He accounts for it from the thickly settled States, the crowded condition of their graveyards, situated on shallow soil, underlined with rock, in which wells are dug, and the people are drinking the filthy and contaminating filtrations, while in the Western States, with a porous soil, the population scarce, and few graveyards, the poisonous fluids have not yet infiltrated the drinking water to any extent.

Dr. Leartus Connor, editor of the *American Lancet*, says: "If one thing in sanitary science is better settled than another, it is that decomposing human bodies pollute both the air above the ground, the ground itself, and the water that percolates through the ground. Polluted air and poisoned water are certainly detrimental to public health."

By cremation, we consume, by the purifying force of an intense degree of heat, all the perishable and corruptible matter, without sowing a single germ of disease into the soil, or giving an impure gas to the air that is not so volatile as to be carried instantly high up, where no living thing can be injured by it.

Again, if cremation were generally adopted, we should hear less of over crowded cemeteries and multiple burials in the same space.

Since every crematorium is provided with a calidarium it does away with burial alive, and there would be no such occurrences as reported in June, at Chicago, of a man being found sitting in his coffin a few days after burial in a vault, very pale and weak from his long fast.

Incineration, forever puts a stop to the desecration of the dead. The grave robber will be thrown out of employment, and there will be no reports of "graveyard horrors," as was given in August, of dogs dragging paupers from their graves in the Canadian capital.

Another argument in favor of cremation is that the final religious services would be performed under cover, and the friends and relatives would not be exposed—as is now often the case—to the danger of taking cold and contracting, thereby, a serious, if not a fatal illness.

The last argument, but not the least advantage attendant upon cremation, is the reduction of much expense in the final disposition of the body.

All over the country funeral extravagances are apparent. A simple, impressive service, without display at the home, or church, or crematorium, cannot but commend itself to all.

In the process of modern cremation, the body is placed in a *closed retort* and reduced to ashes by means of the oxygen of the air heated to a temperature of 2000° or more, uniting with the carbonaceous elements of the body.

The gases are allowed to escape through innumerable vents in the fire-brick and the result is the residuum of about five pounds of ashes. For the welfare of the people and the advancement of sanitary science, the future of this reform needs all the assistance it can obtain from sanitarians and physicians.

"God lent his creatures light and air,
And waters open to the skies;
Man locks him in a stifling lair,
And wonders why his brother dies!

"In vain our pitying tears are shed,
In vain we rear the sheltering pile
Where Art weeds out, from bed to bed,
The plagues we planted by the mile!

"Be that the glory of the past,
With these our sacred toils begin;
So flies in tatters from its mast
The yellow flag of sloth and sin.

"And lo! the starry folds reveal
The blazoned truth we hold so dear;
To guard is better than to heal—
The shield is nobler than the spear!"

O. W. Holmes.

DISCUSSION.

Dr. B. W. James approved of the paper as read, but considered that the cremation process should be extended, so that it will prevent the propagation of disease by burning garbage, etc., not so much to destroy the filth proper, which is only the vehicle, but the germs themselves should be destroyed. He saw great need for cremation where the water was but little below the earth's surface, as in New Orleans; for example, where they cannot bury the dead without walling up the graves, as it is in just such cases that the germs are set at liberty; also, for cheapness, it would be better to have cremation in such instances, and this to include the burning of garbage, etc. He referred to the method which exists in Manchester, England, for the burning of refuse, and the small amount of coal which is required to keep the fire going, as the garbage and other materials to be burned acted, to a certain extent, as fuel. This fire is kept burning all the time; further than this, he would have the sewage boiled and dried. He also believed that water

should be boiled before use, in order to destroy the germs, and the water in the sewers should be heated before it passes into the river, that the germs might be destroyed, and thus prevent contamination of the drinking water; oil will not destroy germs, but they will die from heat.

Dr. S. J. Coe said that she would have referred to the subject in her paper, but did not wish to occupy so much of the Society's time; she believed, not only in the destruction by fire of the garbage and refuse, but also that all animals that die should be so treated.

Dr. Cowley referred to the use of filters in houses, and thought that if the same amount of money were expended by the cities for a better water supply, every individual would be benefited thereby, thus doing away with the necessity for individual water filters.

Dr. B. W. James referred to the pernicious influence which resulted from the washings of the streets flowing into the rivers, thus contaminating the drinking water, which could be gotten rid of if we had a general filter. He believes in the large, rather than the small, filter, owing to the fact that the small filters soon become obstructed.

Dr. H. N. Martin asked if it were not better for each family to burn its own garbage; in that way there would be no trouble in getting rid of all such material, and it would save much expense.

Dr. B. W. James said that the stoves were not properly arranged for such a purpose, and that it would be necessary to construct special stoves for the purpose of burning such material, as otherwise the smoke would be very annoying.

Dr. H. J. Sartain had had some experience in that direction, as the family who had been living next to her, burned all their waste material, the smoke from which was almost unbearable.

Dr. H. N. Martin said the idea was not his own, but had often been spoken of as being practicable.

Dr. E. H. Lang McClure had had a similar experience to that given by Dr. Sartain.

Dr. C. S. Middleton had also suffered the same annoyances.

Mr. Thomas F. Brock, on invitation of the Society, continued the discussion, He said that the burning of garbage in the ordinary range or heater was not practicable. The only proper way to dispose of it in this way is to have for the purpose proper apparatus

which shall first dry the garbage, after which it should be cremated in a closed vessel. The cremation of sewage is probably the most effectual way families can dispose of it. The most efficient way, however, is that in vogue in Massachusetts. The matter is treated chemically and then the liquid is allowed to flow. The solid residue is then collected and used as fertilizer.

A very important question is the removal of sewage and its dis posal. Nothing definite has yet been determined in relation to the matter, especially in our large cities. Sewage is thrown into our rivers and seas.

Sanitary science is, at the present day, very much like disease; it has become what may be called sanitary fever. It has had its various stages. During the last few years it has run high and has got into a condition of delirium. It has now passed through that stage and it is now in a condition of collapse. The National Board of Health has died; the State has organized a State Board under great pressure; but they have asked gentlemen to give their time to a subject which should require *all* their time and insists upon their time being given gratuitously.

Local Boards of Health make laws governing drainage. These laws are, to a certain extent, inoperative, for no one is made responble. The local Board of Health directs how the plumber shall do his work, but assumes no responsibility for the proper performance of the work. Those who are placed in a position to judge of the character of the work done, do not receive proper compensation. The influence of physicians should be wielded to compel legislators to appoint boards of health with executive officers properly compensated.

Dr. David Cowley referred to the curbstone ventilators to drains as a nuisance. They do not work properly, for there being insufficient heat in the drain, the foul air is forced into the steeet. Brooklyn had at one time quite an epidemic of typhoid fever, and wherever these ventilators were, there typhoid fever was the most severe.

Dr. I. T. Talbot said that the question of drainage for Boston was at the present time quite a serious one, and one, too, that had not yet been solved. For awhile the solution was apparently clear. A big pumping basin was built and the sewage was carried out

some six miles where the tide took it in charge. But now by the great increase in the size of the city by bringing in all the towns about, this method is no longer efficient.

Speaking on the subject of traps, Dr. Talbot said that all traps should be ventilated. These ventilators should be carried to the tops of the houses. Still the methods of doing this are not efficient. Let any one open a window in one of the upper stories of any of the high buildings of New York. He sees thousands of ventilating tubes all of which give off foul air which enters the room at once.

Dr. Talbot also said that he thought the disposal of sewage by cremation to be the most scientific way of treating it.

Mr. Brock said that the trouble with the ventilating tubes of which Dr. Talbot spoke could be obviated. It requires, however, the united practice of all citizens. The objectionable feature is the placing of the trap on the main drain as it enters the house. The practice that he has followed for the past twenty years, is never to place a trap on the main drain. In this respect, he antagonizes all the board of health rules that have been adopted. He places traps on branch pipes as close to the main drain as possible, using one trap for as many fixtures as can possibly be concentrated on that trap. He ventilates each waste pipe in such a manner as to cause a current of air to continuously pass through the same and out through the heat flue to the top of the house, the ventilating pipe being carried far above the tops of the houses.

REPORT OF THE BUREAU OF PÆDOLOGY

Was next presented. It embraced the following papers:

Morbus Coxarius, by H. M. Bunting, M. D., Norristown.

The Statistics of Croup and Diphtheria, by W. B. Trites, M. D., Philadelphia.

Sporadic Cases of Scarlet Fever and Diphtheria, by Hugh Pitcairn, M. D., of Harrisburg.

Convulsions in Children due to Sympathetic or Reflex Irrita-

tion, by C. S. Middleton, M. D., of Philadelphia.

Infant Feeding, by Lora C. Jackson, M. D., of Philadelphia.

MORBUS COXARIUS.

BY H. M. BUNTING, M. D., NORRISTOWN.

On June 1st, 1885, I was summoned to see Morgan L., a child of three years, with light complexion, blue eyes, and of a bright, cheerful disposition, seemingly enjoying the best health. He had, until within a few days, been under the care of an allopathic physician, who pronounced his case one of rheumatism, and had been treating him for a few weeks with no improvement; on the contrary, he continued to grow worse.

He now complained of pain in the left knee, stiffness in the hip, especially in the morning, with a tired feeling in the leg after walking, which was accompanied by limping; the left foot was abducted, somewhat everted, the leg partly flexed and seemingly lengthened. I had his clothing removed, and on standing him in front of me, saw a decided flatness of the nates on the affected side, with drooping; the gluteo-femoral crease was lower than on the sound side, and nearly obliterated, with a lowering of the pelvis of left side. Placing him now on a table on his back, and raising the thighs until the vertebral column touched the table through its whole extent, I brought down the suspected limb, but found a tilting upward of the pelvis; on raising the leg again, and striking the heel with my hand, he complained of severe pain in the hip joint.

I could get no history of traumatism, and he had been considered a very healthy child up to within a few weeks of my seeing him; his mother informed me that he frequently wet the bed at night, and I, therefore, examined the penis, and found the fore-skin extending about one-fourth of an inch in front of the glans, with an opening that disclosed but little more than the meatus.

Here, then, we may place the cause of the trouble, for Mr. Barwell argues that the relation existing between hip disease and phimosed children, or rather the influences that create it, are these, "that phimosed children have facile, frequent, and long-continued

priapism; that this condition, unnatural in the infant, must produce after a time, a certain irritability or irritation of the lumbar spinal cord, that from this part the various nerves of the pelvis and lower limbs are given off; that the influence of spinal irritation on the trophic nerves is well known, and that just at this particular period large trophic changes are in progess about the hip joint."

I pronounced the case, then, one of hip joint disease, and ordered the child to bed, to be kept there until all pain and symptoms of inflammation had ceased; his temperature now was 100°. I gave him Bell.[3] every four hours.

The first few nights he complained of pain in hip, was restless, and had involuntary urination. I saw him again, found temperature normal, some hip pain, good appetite, and continued Bell.

The treatment of perfect rest was kept up for about six weeks, and until after all pain had ceased, then he was allowed to take daily rides. His appetite had not been very good for the last two weeks of his confinement, and he was extremely restless, tossing about day and night. I prescribed Rhus tox. with benefit, after which I gave him Calc. carb.[3] for three weeks; he was allowed now to use his leg a little each day after getting out of bed, until he would go around without restraint; he complained of no pain or soreness, and the limping and abnormal position of leg and foot were entirely gone.

On July 26th, he was attacked with measles, which again confined him to his bed, much against his desire, and for which he received Puls. and Sulphur. Recovering from this I allowed him to run around as much as he pleased, his appetite returned, and with it increased strength, and since then he has never complained or shown any symptoms of hip trouble.

THE STATISTICS OF CROUP AND DIPHTHERIA.

BY W. B. TRITES, M. D., PHILADELPHIA.

It is not the intention of this paper to present statistics of the results of treatment in croup and diphtheria, nor is it written with a desire to provoke a discussion of that already much

discussed subject, the identity of these two diseases, but rather to call attention to certain statistics, which, in the writer's opinion, have not received the consideration they deserve, and to draw therefrom certain allowable conclusions, which, he thinks, may be of value in the prevention of diphtheria.

I was first led to compare the death rates of croup and diphtheria in Philadelphia by an article in the Philadelphia *Medical and Surgical Reporter* of August 26th, 1876, giving the results of old school treatment in an epidemic of diphtheria, which had prevailed in the twenty-first ward.* The author claimed to have treated during the epidemic, 1,047 cases, with a loss of but twenty-one. Of those dying, eight were moribund when he was called, and two refused all treatment; deducting these, his death rate was but a fraction over one per cent., a phenomenal success in diphtheria. I cannot describe my feelings on reading this article. For a time my faith, in both myself and the system of medicine I profess, was shaken. Can it be possible, I inquired, for the old school to do so much for this terrible scourge, while homœopathy, as applied by me, eliminating all cases which were moribund when first seen, or which refused treatment, showed a loss of from seventeen to eighteen per cent. in about four hundred cases?

I felt sure that the author of the paper had included in his 1,047 cases many which were not diphtheria, for I had myself seen many cases of folliculitis, which, in the alarm of the hour, I had treated as diphtheria, but which were afterward properly diagnosed; but assuming this error, the disparity between our results still remained enormous.

I anxiously began a search for the cause of this great disparity. I found, from the books of the old school, that it could not have been due to the treatment, for he had used the ordinary supporting treatment of milk punch, iron, beef broth and washes. In the reports of the Board of Health, for 1875 and 1876, the mystery was made plain. I found in these that, in 1875, seventy-two deaths from diphtheria and thirty-eight deaths from croup had occurred in the twenty-first ward.

*The twenty-first ward is a rural section of the city, with a population, in 1876, of 18,097. The epidemic referred to began in the spring of 1874, and reached its height in the fall of 1875, during which year one person in every 237 died of the disease.

In 1876, thirty-nine deaths from diphtheria and twenty-three deaths from croup had occurred.

In 1873 and in 1874, when diphtheria was not prevailing in the ward, the death rate from croup had been four and six, respectively.

Here was, beside a high death rate from diphtheria, an unprecedented mortality from croup, and yet, in my practice, I had not seen a single fatal case of croup, but the most of my fatal cases of diphtheria had died from invasion of the larynx.

This explained to me the phenomenal success of my neighbor; he evidently did not count the death of a patient dying with diphtheritic croup as a loss from diphtheria. This experience led me to believe that membraneous croup and diphtheria are often confounded and prepared me to agree with those who adhered to the theory of their identity, in the discussion of the question by the Royal Medical Society in 1879.

Since 1875 I have carefully watched the statistics (of these diseases) in Philadelphia, as well as in other cities, and have been surprised to find how their mortalities keep pace. The average death rate, per week, from diphtheria and croup, in Philadelphia, during the last ten years has been as follows:

	Diphtheria.	*Croup.*		*Diphtheria.*	*Croup.*
1875	12.5	9.6	1880	6.2	5.8
1876	11.6	7.4	1881	8.8	6.
1877	8.8	6.5	1882	17.9	8.9
1878	8.9	7.4	1883	19.3	9.6
1879	NOT OBTAINED.		1884	13.	11.1

In this table it will be noted that whenever the death rate from diphtheria is high, the rate from croup also advances, and when that of diphtheria decreases, the rate in croup also lessens. This is especially noticeable in the first six years (of the table) and not so marked afterward, because I think that in the later years, the attention of the profession has been aroused to the fact that diphtheria is a frequent cause of croup. If we compare the death rates of these two diseases, week by week, as has been done in these charts,† we will find this correspondence still more manifest, the

†Here the writer exhibited ten charts, showing the deaths each week, for ten years, from diphtheria and croup in Philadelphia.

death rates advancing and declining just as in the table of average weekly mortalities.

Neither time of season nor atmospheric condition, seems to retard or accelerate one disease beyond the other, they go, hand in hand, through all seasons and in all kinds of weather. In 1875 and 1882, the highest mortality in both diseases was exhibited between the first of October and the last of December.

In 1876 it was highest from the first of January to the first of July, while in 1883, the mortality was frightful, and was distributed evenly over the entire year.

Thus far in my investigation, the statistics seemed to show that the death rate from croup, in any given year, bore a striking similarity to the death rate from diphtheria for that year; that when the average death rate per week was taken, the same correspondence was seen; that when charts were made showing the actual death rate for each week, both croup and diphtheria, the death rates were found to correspond week by week, and finally this similarity was not confined to any particular season nor dependent upon atmospheric conditions. I thought if I could follow up this examination and compare the results in localities, and should find that the deaths from diphtheria and from croup, occurred not only in the same week, but in the *same localities*, a strong argument would be adduced to prove that, either these diseases were identical, or else that they occurred together. In pursuance of this thought, I made an examination of the weekly returns of deaths by wards, as reported to the health authorities of Philadelphia, and found that when the death rate for any week from diphtheria is high in any ward, the death rate from croup for that ward and week is also high, and *vice versa*. In some years this high mortality was found in the thickly settled and badly constructed portions of the city, other years in the finely built neighborhoods, such as the 15th and 20th wards; and in other years, in the rural wards, such as the 21st, 22nd, and 28th wards, but always with the peculiarity, that if a high death rate from diphtheria is reported, a high death rate from croup is also reported.

These investigations lead me to think that if the diseases which we call diphtheria and croup are not identical, they are, at least, apt to prevail at the same time, and in the same localities. No

one denies the similarity between croup and laryngeal diphtheria, nor is the contagiousness of diphtheria disputed by any considerable number in the profession.

The very obvious lesson to be drawn from these facts, is that patients suffering from croup, should be placed under the same restrictions, as to association with the public attendance upon schools, and disinfection as are required in patients attacked with diphtheria. Yet in the city of Philadelphia, no such quarantine of croup patients is exacted by the authorities; and some physicians, holding to the dual origin and character of the diseases, deride such a suggestion. May not this very fact account for the long continued epidemic of diphtheria in Philadelphia. The following table shaws that for over ten years, the death rate from this cause has been in the hundreds.

Table showing the number of deaths each year from Diphtheria and Croup.

	Diphtheria.	*Croup.*		*Diphtheria.*	*Croup.*
1872	150		1879	321	
1873	110		1880	523	303
1874	179		1881	457	317
1875	652	428	1882	933	466
1876	708	386	1883	1006	500
1877	458	338	1884	680	579
1878	464	388			

I am convinced that one cause of this long continued prevalence of diphtheria, is due to carelessness, resulting from the widely spread error, among the laity, that croup is not contagious, and to the fact that many cases of laryngeal diphtheria are treated under the name of croup, and no effort made to quarantine the patient. I am an advocate of the best sanitary conditions possible for our great city, clean streets, improved pavements and perfected sewer systems. I want every appliance the ingenuity of man can suggest, to prevent the introduction of the germs of diphtheria into our homes, but I believe that in an effort to stamp out diphtheria, it is more important, for us to recognize the fact that this disease is often mistaken for croup, than it is for us to build the most per-

fect sewers, or to introduce the most efficient traps and other sanitary apparatus.

The State Board of Health should call special attention to the similarity existing between croup and diphtheria, and urge upon school boards and local health boards the necessity of the closest quarantine in every case of croup.

SPORADIC CASES OF SCARLET FEVER AND DIPHTHERIA: TREATMENT AND NOTES.

BY HUGH PITCAIRN, M. D., HARRISBURG.

CASE I.—*July 3, 1882.*—Ellen S., æt. 8 years, lives at corner of two streets, where there is a sewer inlet for water and filth, and outlet for disease and death. The parents sent to my office for medicine for malaria, all the family (six or eight persons) being affected with chills, fever and sore throats. The child had had slight chills, followed by fever and perspiration. ℞ China.

July 4.—I was sent for and diagnosed scarlet fever. Symptoms were, throbbing headache, ophthalmic congestion, vomiting of greenish fluid, slightly red sore throat; temperature 102°, with moisture of skin; pulse 130; slight delirium. ℞ Ipecac.[3], Bell.[6]

July 5.—Rash well developed over upper part of body; typical scarlet fever; nausea disappearing; fever abating; every way more comfortable. ℞ Bell.[3].

July 6 to 8.—Rash spread over lower extremities of a smooth red character, unattended with any violent symptoms. ℞ Bell.[3].

July 9.—Tongue getting pale and of natural color and appearance; from this time desquamation from usual course, resulting in complete recovery, without sequellæ; except slight earache. ℞ Calc. carb.[30], Puls.[6], Sulph.[30].

CASE II.—*July 10, 1882.*—Master James S., æt. 5 years, brother of Case No. 1, complained of sore throat, high fever, nausea, vomiting, headache, frontal and throbbing; tongue heavily coated yellowish; restless, tossing and moving in sleep. ℞ Bell.[3].

July 11.—Rash and symptoms same character as developed by his sister, and, under same remedy, ran a mild course, until

July 14.—When the rash paled a little, and his feet were slightly swollen, with urine partially suppressed. ℞ Apis[30].

July 15 and 16.—Much improved, urinary symptoms having disappeared. From the latter date to perfect convalescence, after complete and extensive desquamation; the case was a very mild case of scarlet fever, without sequellæ. ℞ Sulph.[30] and Calc. carb.[30].

Case III.—*July 15, 1882.*—Miss E. M., æt. 25, school teacher, sister of Cases Nos. 1 and 2, and living in same house, complained of general malaise, chills followed by fever, throbbing headache, nausea and bilious vomiting, backache, very slight sore throat. Temperature, 101°; pulse, 110. Notwithstanding the report that she had had scarlet fever, I diagnosed the case as such, and gave Bell.[3].

July 16.—All symptoms aggravated. Examination of throat showed diphtheritic deposit on tonsil, left side; temperature, 102°; pulse, 120; splitting headache. The deposit on throat continued to spread during the day, till it involved both sides, extending posteriorly and covering posterior larynx. ℞ Merc. iod.[2x], and gargle of alcohol and water.

July 17.—Throat seems clearer, though prostration is extreme; headache less. ℞ continued.

July 18 to 20.—There is continued improvement, throat clearing up; from this time convalescence is gradual.

July 20.—Pain in occiput and spinal column, with slight paraly- of vocal cords, which disappeared under Gels.[6], Sulph.[30].

Note.—At the same time I was attending these cases the eldest of the family, a lady of thirty-five years, was prostrated with a severe attack of chills and fever, with throat symptoms of a light grade, but was, however, under the influence of Quinia sulph. in large doses.

Case IV.—*Nov. 21, 1885.*—Frank E., æt. 12 years. Father is a shoemaker, very filthy, dirty house. Lives in a filthy locality and exposed to a bad vault. The whole family suffers from chills and fever, mother supposed boy was so afflicted; headache, fever, aching in limbs, general malaise, etc. ℞ China.

Nov. 22.—I called at his home and found patient with high fever. Temperature 102°, pulse 125; sore throat with white patches

on both tonsils especially on left side; salivation. ℞ Merc. jod. rub.^{2x}, and gargle with following:

℞.	Hydrarg. bichloridi,	gr. j	
	Thymol (crystals),	gr. j	
	Alcoholis,	℥ss	
	Aqua pura,	O. j	M.

Sig.—Use as a gargle every 2 or 3 hours.

Nov. 23.—Nausea and vomiting; throbbing in head; ophthalmic congestion; tongue heavily coated and scarlet fever rash appearing on upper part of the body. Throat cleaned of most of the patches, though red and highly inflammed. ℞ Bell.^{3} and whiskey.

Nov. 24.—Throat clean and much improved. The rash covers the whole body and is smooth variety; fever abating. Pulse 110. ℞ Bell.^{3}.

Nov. 25, to Dec. 1.—Throat improving rapidly under Bell.^{3}, and under it and whiskey, the patient passed through a typical case of scarlet fever, mild in character, without unfavorable symptoms or sequelæ. Desquamation being general and excessive.

Note.—I gave the mother a lecture on "the next grace to godliness;" the exceeding contagiousness of the disease and the necessity for thorough work in cleaning up, with use of disinfectants, expressing fear that the daughter two years older might contract the disease unless great care was observed.

Case V.—*Feb. 4.*—Lena E., æt. 14 years, sister of Case No. 4, complained of sore throat and bilious vomiting; prostration and fever, and sent for medicine. ℞ China. Her throat growing worse, and showing diphtheritic deposit during the day. I called and changed to Merc. iod. rub.^{2} and Bell.^{3}, with gargle as given in Case 4.

Feb. 5.—Seems much better; throat cleaned up, and able to be about the room, felt so well that she asked if she might not go down stairs to her dinner. I reluctantly gave consent, and, as I expected to be out of town next day, I gave instructions for her to be very careful, and not to expose herself, and to continue the treatment.

Feb. 8.—When I returned, I found I had been sent for repeatedly during the day, the patient had ventured into the out-house, which evidently contained the poison, and had taken cold, it being

very damp weather. When I called I found her in very bad condition. Face badly swollen, right eye almost closed. Sanious discharge from the nostrils; heavy diphtheritic deposits. Pulse 140, temperature 105°. Comatose condition; inability to swallow; delirious; after she was unable to use gargle, disease progressed very rapidly with symptoms of convulsions. ℞ Cuprum acet[6]. Immediately before, or during, her dying moments, a slight rash, not unlike scarlet fever rash, appeared on tibia, also blue spots all over the body.

NOTE.—The house had not been cleaned, and I found, upon questioning, that the same bed clothes used for the brother who recovered, were on the dead girl's bed without being washed.

CASE VI.—*Dec. 16, 1883.*—Mr. G. A. F., æt. 32, married. One child. Has suffered from repeated attacks of malaria, for which I treated him. The house in which he lived is near the outlet of a very foul sewer. He was attacked with nausea and vomiting, pain in the head and limbs, and general malaise. I thought he was having a return of his old enemy. Especially as I knew of no scarlet fever in the city. ℞ Ipecac[1x] trit.

Dec. 17.—Throbbing carotids, aggravation of other symptoms, and very sore throat, again on left side. Throbbing and feeling of fullness. Diphtheritic patches, dirty and gray, covering both tonsils. Temperature, 103°; pulse, 130. ℞ Bell.[6x], Merc. iod. rub.[1x], also gargle of alcohol and water.

Dec. 18.—Thick, yellow, furred tongue, aggravation of all symptoms. Voice heavy and thick. Delirium, but throat a little clearer; however, he is unable to swallow anything but liquids. "Throat burns like pepper." ℞ Caps.[3x].

Dec. 19.—Scarlet fever rash appearing on chest, arms, and face. Throat symptoms better. ℞ Bell.

Dec. 20.—Tongue begins to clear off a little on the tip, which continues until it assumes the bright strawberry tongue of fully developed scarlet fever.

Until the 24 rash which was intense and of a bright smooth, variety spread all over body. Throat still burns, is bright red and sore, but fever and all symptoms gradually abating. ℞ Bell.[3] and Caps.[3x].

Dec. 24 to Jan. 1.—Desquamation and convalescence continue

under Sulph.[30], with final perfect recovery without bad symptoms, except a slight tendency to paralytic condition of lower extremities, which, however, passed in a few years.

No sequel.

NOTE.—In the immediate vicinity of the patient's house, there were a number of cases of diphtheria and malaria, and as far as I could ascertain no case of scarlet fever either before or subsequently. The patient was in no way exposed to the contagion of scarlet fever.

CASE VII.—*Jan. 4, 1886.*—Mr. Harry H., æt. 22 years. Resides with his sister, who occupies a corner house in a row of three story brick houses put up for rent, and having each, in the rear, outhouses with boxes under them and no outlet. These soon became filled with all manner of filth, which ran over the surface of the ground, became frozen, and when weather became mild, so offensive, that it is a mystery why the whole neighborhood was not affected.

Mr. H. complained of chill followed by dry, hot skin. Temperature 101°. Pulse 130. Headache throbbing; ophthalmia; congestion; sanious discharge from nostrils; very sore throat which was œdematous; uvula elongated. Had scarlet fever in his childhood. ℞ Acon.[2] and Bell.

Jan. 5 and 6.—Diphtheritic patches on both sides of throat with aggravation of all the other symptoms. Inability to swallow water; comes out of nostrils when swallowing; extreme weakness; pains in back and limbs; constipation; metallic, offensive taste; breathing hard; skin changed to clammy feeling. Temperature 102°. Pulse 140. During the day, membrane spread all over throat and up into posterior pharynx. ℞ Mer. iod. rub.[2x], tinct. as a gargle.

℞.	Hydrarg. bichloride,	gr. j	
	Thymol (crystals),	gr. j	
	Alcohol,	℥ ss	
	Aqua pura,	Oj.	M.

SIG.—Use as a gargle every 2 or 3 hours.

Jan. 7.—Is slightly improved during the day; large quantities of the membrane being tough, fibrous in character loosened by the gargle and expectorated. Treatment continued.

Jan. 8.—A. M.—Is no better; rather worse. Expectoration of

tough and stringy mucus; constricted feeling about throat. Glands swollen more; seems to have involved the nostrils. ℞ Kali b.^{3x}.

Jan. 8.—P. M.—Is much worse since having a sleep. Lachesis^{30}.

Jan. 9.—Seems better; not so great prostration, but throat more swollen; delirium; inability to keep patient in bed. ℞ Lachesis.

Jan. 10.—Increase of fever; symptoms of fresh cold; skin dry and hot. Temperature 103°. Pulse 140. Acon.^{1}, Lachesis^{30}.

Jan. 11.—Is better; throat clearing up; large pieces of membrane ejected by use of the gargle.

Jan. 12.—Is doing well; temperature 100°, pulse 110. ℞ Lachesis and Sulphur; but throat being clean, gargle stopped.

Jan. 15.—Temperature and pulse normal; throat clear; able to take nourishment freely. ℞ Sulph.^{30}.

From this time, he gradually regained his strength and flesh, and resumed his occupation January 25, without sequelæ.

NOTE.—In the same house, while Mr. H. was sick, the servant girl developed symptoms of diphtheria, and by my advice was sent to her home in the country, where she had an attack of diphtheria, without any scarlet fever symptoms.

CASE VIII.—*Jan. 12, 1886.*—Elenore H., æt. 5 years, the niece of Mr. Harry H., Case No. 7, and living in same house, complained of slight chill, fever and sore throat, which looked red and inflamed; drowsy; inclined to lie about; loss of appetite; throbbing headache. ℞ Bell.^{6}.

Jan. 13.—Sore throat, nausea and vomiting of bilious matter; throbbing headache; pains in limbs; pulse 130; fever high; refuses food. ℞ Bell.^{6} and Ipecac.^{3}.

Jan. 14.—Scarlet fever, rash smooth and scarlet, appears on upper part of body; throat symptoms better; throbbing headache, aggravated from motion; pulse 130; temperature 103°; no appetite. ℞ Bry.^{3}.

Jan. 15.—Is doing well; temperature 100°, pulse 110; rash well developed all over the body; is intensely scarlet; partakes freely of milk punch. ℞ Bell.^{6}.

Jan. 16, A. M.—Rash paler; dropsical symptoms; drowsiness—Apis^{6x}. P. M., pulse 130, temperature 102°; urine suppressed. ℞ Apis^{30} and hot applications over kidneys.

Jan. 17.—Is better; passed urine, and dropsical symptoms disappearing; moisture; pulse 120, temperature 100°. ℞ Bell.[3]

Jan. 18.—Delirium; skin hot, dry; temperature 103°, pulse 140; rash paling; desquamation; exceedingly restless, tossing about; pains in stomach; anguish; thirst; she has taken cold from sudden change in weather, snow storm. ℞ Acon.[1].

Jan. 19.—Slept better; restlessness subsided; skin moist; temperature 100°, pulse 110. ℞ Bell.[3]

Jan. 20.—Is better; temperature and pulse about normal; appetite returning. ℞ continued. P. M.—Tonsils swollen; aggravation on left side; neck stiff. ℞ Rhus[6].

Jan. 21.—Desquamation almost complete; neck and throat better. ℞ Calc. carb.[30] and Sulph.[30].

Jan. 27.—Seems to have taken cold; neck stiff; both tonsils enlarged. ℞ Rhus[30].

Jan. 28 and 29.—Is much better. ℞ Calc. carb.[30], Sulph.[30].

From this time patient progressed rapidly to perfect health, which, however, was not complete until an abscess developed on left side of neck, and was discharged, and healed kindly without scar.

Case IX.—*Jan. 14, 1886.*—Mary H., æt. 3 years, sister of Case No. 8, developed similar symptoms to her sister, but more intense; high fever; sore throat; drowsy; nausea, and vomiting of yellow bilious matter; bright scarlet fever rash; pulse 130, temperature 102½°. ℞ Bell.[3].

Jan. 15.—Rash well developed all over body, but throat badly swollen; refused all attempts to give food or nourishment; fluids return through nose; nose bleed; examination of throat showed diphtheritic patches on both sides; foul odor to the breath; excoriated nostrils and lip. ℞ Nit. acid[6x].

Jan. 16 and 17.—Symptoms grew worse; comatose state, with delirium; lies with half open eyes, head thrown back; rash very pale and poorly developed; rolling of head in pillow; Case hopeless. ℞ Opium, Lachesis and hot pack.

Died January 17, at 6:30 A. M. My first fatal case of scarlet fever. Post-mortem showed diphtheritic deposits covering fauces.

Case X.—*Jan. 18, 1886.*—Mrs. E. K. H., mother of the two cases above, Nos. 8 and 9, and sister of Case No. 7; sore throat;

pain in back; nausea; vomiting; scarlet fever rash appearing on upper part of body; had been feeling badly for several days, with fever, but attributed it to watching and care; tongue heavily coated; great prostration. ℞ Bell.[3].

Jan. 19.—Drowsy; sleepy; temperature 103°, pulse 130. ℞ Bell.[3].

Jan. 20.—Temperature and pulse reduced and otherwise also better; rash, over whole body very dense, but patient exceedingly weak. ℞ Bell.[3].

Jan. 21.—Great weakness; prostration aggravated by motion; retrocession of eruption. ℞ Bry.[6].

Jan. 22.—Is better; rash more marked; tongue and throat sore. ℞ Bry.[6], Sulph.[30].

Jan. 23.—Is better; fever and pulse much reduced.

Jan. 24 to Feb. 2.—Case progressed, under Calc. carb.[30] and Sulph.[30], to complete recovery, without bad symptoms or sequelæ.

NOTE.—There were several cases of scarlet fever, and also of diphtheria, in the next two houses.

CASE XI.—*June 6, 1886.*—Master B., æt. 2 years, lives in a small frame house, yard very small, and the privy vault near kitchen door, at times overflowed, etc. High fever; eyes congested; throbbing headache; nausea, and vomiting of green bilious matter; great prostration; tongue heavily coated; pulse hardly countable; slight rash, very fine on the neck; convulsions. ℞ Bell.[6].

June 7.—Scarlet fever rash well developed; convulsions continue; comatose state; refuses drink; throat very red and sore; temperature 103°, pulse too rapid to count. ℞ Bell.[3], Ailanthus and whiskey.

June 8.—Rash all over body; tongue has the characteristic strawberry appearance; convulsions less frequent and severe; fever abated; pulse regular and full, 125; child playful and partakes freely of milk and whiskey. ℞ Ailanthus.

June 9.—Slight perspiration; temperature and pulse normal. ℞ Ailanthus.

June 10 to 20.—Case continues perfectly comfortable; tongue clears up; desquamation extensive. ℞ Ailanthus and Sulph.[30].

There were no bad symptoms after June 8, and no sequelæ of any kind.

CASE XII.—*May 22.*—Lillie H., æt. 12 years, lives in neighborhood of a sewer inlet, is an unusually large and robust child for her age. Menstruation already established. Complained of headache; eyes congested, tongue heavily coated, face flushed, throat inflamed. Is now menstruating. Scarlet fever rash all over upper part of body, bluish, prostration, loss of appetite, dizziness. ℞ Ailanthus.

May 23.—Slight throbbing headache, rash general over whole body, bluish in appearance. ℞ Bell.[3] followed by Ailanthus.

May 24.—Temperature 104½°, pulse 150, rash well developed; slight wandering of the mind; restlessness; sleep light. ℞ Ailanthus.

May 25.—Temperature 104¾°, pulse 160; slight delirium; eyes sparkling, congested; heart, violent; urine, scanty and strong, ℞ Ailanthus with teaspoonful doses of whiskey every three hours.

May 26.—Temperature 103,° pulse 140; urine suppressed, otherwise better; less headache and mind clear. ℞ Ailanthus and whiskey with hot pack over kidneys.

May 27.—Is much better; urine passed freely and in very large quantities after hot pack yesterday; temperature 99, pulse 90; mind clear; sore throat; fine bright red tongue begins to fade; 9 evening comfortable, but sleep still uneasy. ℞ Ailanthus

May 28.—Temperature 99°, pulse 100; sleeps well; desquamation begins. ℞ Ailanthus.

May 29.—Temperature and pulse normal; partakes freely of milk and other nourishment. ℞ Ailanthus.

May 30.—Urine partly suppressed; exceedingly restless; desquamation continues. ℞ hot pack, Ars.[3].

May 31.—Urine passed in large quantities, and freely after hot pack and Ars.; is quiet and restful. ℞ Ailanthus.

May 31, to June 12.—Convalescence, progressed, also general desquamation without unfavorable symptoms, to complete recovery and without sequelæ.

CASE XIII.—*July 26, 1886.*—Master B., æt. 20, lives in a filthy part of the city. Yesterday was taken with slight chill, followed by high fever. Throat slightly sore; headache and aching through body. This morning throat highly inflamed with enlarged tonsils

covered with white patches. Exceedingly offensive breath. Eyes highly inflamed; great prostration; throbbing headache. ℞ Bell.[3], Merc. iod. rub.[2].

July 27.—Nausea and vomiting large quantities of bile, chill followed by fever and heavy sweat without relief. Head sensitive to touch; has chills and fever before, and thinks this is what is troubling him. Throat seems a little better; yellow, furred tongue; very sensitive to every breath of air; body sore all over; yellow, jaundiced condition of skin; cannot sleep; hepatic region sensitive. ℞ China, Merc. iod. rub.[3].

July 28.—A. M.—Throat better, but other symptoms about the same. Throbbing headache; face flushed; eyes congested, and slight appearance of a bluish rash under the skin on neck. Pulse 130. Temperature 102°. ℞ Bell.

July 28.—P. M.—Rash more distinct. Diagnosed scarlet fever from the rash. Patient exceedingly restless. ℞ Ailanthus and whisky.

July 29.—Rash developed very fast under Ailanthus, covering whole body; temperature 102°, pulse 130; throat is much inflamed, but no patches; tonsils swollen; swallowing difficult; exceedingly weak. ℞ Ailanthus, Whiskey.

July 30.—Rash is general and quite slight; tongue dry, throat dry, with burning, stinging pains; temperature, pulse and other symptoms about the same as yesterday. ℞ Ailanthus[6x], Apis[6x].

July 31.—Is very much better; throat gives little annoyance, rash becoming pale on the face and neck; tongue bright strawberry red; temperature 99°, pulse 98; is much better every way. ℞ Ailanthus.

August 2.—Temperature and pulse are normal; desquamation proceeds satisfactorily; tongue getting pale; urine scarce. ℞ Sulph.[3x] and Ars.[3], few doses each, followed by Ailanthus.

From this time on to August 7, when I made my last call, desquamation and convalescence continued, without interruption, and, as I learn since, without sequelæ, under Ailanthus and a few doses of Sulph.[30].

TREATMENT AND NOTES.

In the treatment of both scarlet fever and diphtheria, I believe in the use of adjuvants. The first few cases I had of diphtheria I

relied entirely upon the indicated homœopathic remedy, and I met with fair success; but because I desired more satisfactory results I gradually came to the practice of what some may call "mongrel homœopathy," and the results have been so satisfactory to me that I would not wish to combat either of these hateful diseases without such help.

In diphtheria, I use the gargle given above with the best selection I can make from our materia medica. I am indebted to Dr. Fox, of Baltimore, Md., for the prescription. Since its use I have not lost a case who was able to use the gargle. It may be asked what better results I have than the old school, who rely wholly upon such treatment. My reply is that, in an epidemic of diphtheria, where the best old school practitioners admitted losing twenty-five to thirty-three per cent., my percentage of losses was but eight. I also stimulate with milk punch.

In scarlet fever I isolate my patients in the upper part of the house. I make the room moist and prevent egress of dust, etc., from the room by hanging a wet sheet over the door. I have all unnecessary articles removed from the room; and when desquamation begins, I have patient annointed freely with cocoa butter. I find this destroys the disagreeable itching, gives ease and comfort, reduces the temperature of the body, and prevents extension of the contagion to other members of the household. In addition to the indicated remedy, I give teaspoonful doses of whiskey every three or four hours, or a whiskey milk punch, being firmly of the opinion that whiskey is an antidote to the poison of both diphtheria and scarlet fever. Immediately on the exhibition and use of rye whiskey in either disease, the thermometer will show a decrease in the temperature of the body.

Prophylactic treatment to other members of the family invariably, by the use of our time-honored remedy, "Bell.," now also in use by the old school for the same purpuse. I also give frequent hot sponge baths during very high temperature of body.

Diphtheria is a disease of miasmatic contagious nature, and I believe infectious as well. Some claim that bacteria or parasitic fungi are the cause, while others claim that the cause is a specific poison unknown (or unknowable), or very imperfectly understood. It certainly is a dynamic disturbance of the vital function: the lat-

ter is my opinion. I believe that the bacteria are only a product of the disease, holding a similar relation to the disease existing between some plants and their foliage, nourishing and sustaining life.

In studying the above cases, with many other similar cases with their environment, I bring myself to ask the following questions:

First.—May not the poison of diphtheria and of scarlet fever be identical, developing the one or the other (either diphtheria or scarlet fever) according to the soil brought in contact with the disease producing agent, or because of some peculiar idiosyncracy of the patient?

Second.—Will not the miasm contagion or infection of scarlet fever produce diphtheria in a patient who has had scarlet fever?

Mr. H., case 7 had had scarlet fever in his youth.

Third.—May not the poison which produces scarlet fever develop diphtheria in adults, who are less liable because of their age?

One of the objects I have in reporting these clinical cases, is to call attention to Ailanthus as an invaluable remedy in all forms of scarlet fever. In those imperfectly developed cases which are more likely to be malignant, it quickly changes the dark mottled condition of the skin to a perfectly developed rash, (see Hale and Cowperthwaite,) and in all cases it causes a satisfactory development of the exanthem, imparting a benign character to the disease.

CONVULSIONS IN CHILDREN, DUE TO SYMPATHETIC OR REFLEX IRRITATION.

BY C. S. MIDDLETON, M. D., PHILADELPHIA.

Fortunately, the causes of convulsions in young children are more frequently traceable to reflex excitement, than to real pathological conditions, and, as a rule, more easily removable.

It will be the object of this paper to direct attention to some of these causes, distinguishing, when we can, the one from the other, that relief may be more prompt and serious results averted.

All physicians are aware of the extreme sensitiveness of the nervous systems of infancy and early childhood, and are, therefore, not unmindful that susceptivity is the first great factor in producing these alarming conditions. Like the sensitive plant which takes cognizance of the slightest touch, so the nervous system of an infant resents an infraction of Nature's laws; therefore, from the moment of birth, when, by too much pressure from forceps, to which the head may have been subjected, torsion, extension, or some other procedure, by which irritation or injury may have been received, trismus or general convulsions may follow, and until long after the last molar of the first teeth shall have been "cut," children are subject to convulsions from a variety of sources. For convenience, the causes of convulsions in general, may be divided into accidental and special, the latter again being sub-divided into reflex and pathological. All cases not incidental to a disturbed natural growth and development of the child, we would term accidental, such, for instance, as fright and emotional effects.

Among the special causes, it is probable that febrile effects stand first; irritation from dentition, second; irritation in the bowels, third; and indigestion, last.

These, though special, are all reflex causes, to distinguish which from the pathological is not always easy; for instance, when an infant, say from three to twelve months of age, shall have been taken ill with, first, a high fever, hot head, nervousness, twitching, and, finally, a convulsion, we cannot at once say that the spasm is of less serious consequence than it would be if hydrocephalus is about to set in; the history of the case, stage of illness, constitution, shape of the head, etc., will largely influence us in the diagnosis, which should always be guarded.

If an infant escape trouble of this kind before dentition is in progress, it may be more easy to attribute a special cause for the convulsion. It is not necessary that teeth should show by their pressure in the gum, to produce the above result; quite as much irritation to the nervous system is capable of production when these troublesome additions to our comfort are but developing within the alveolar process. When, however, the former shall obtain, and, as is often the case, effusion and suppuration over the crown of the tooth be present, great relief can be secured, and fre-

quently the convulsion broken, by lancing the sac, or even an engorged and inflamed gum, or one where tension is severe and the tooth nearly through.

Indiscriminate lancing, however, is not to be recommended; but too often physicians of our school refuse this relief, when it is culpable practice to omit it. It is better, always, to search for reflex causes without delay, because, if such a condition exist, other measures than medicinal are frequently and promptly needed, whereby we save much time, suffering and danger.

Convulsions, produced by irritating influences in the intestinal tract, are of more frequent occurrence than is supposed. These are chiefly due to undigested food, impacted fæces, invermination, etc. These points should be clearly ascertained, and the treatment applied accordingly.

It is often astonishing how frequently mere constipation will produce convulsions in a susceptible constitution. Just here one cannot be too careful in affording the necessary relief by the use of enemas, and, to avoid being deceived as to results, personal supervision will often be necessary. Particularly is this the case where large scybala are impacted in the rectum, and where enemas have produced only partial and unsatisfactory results. Convulsions, arising from undigested food within the stomach, or from some hard substance swallowed, are probably of less frequent occurrence than from other causes, on account of the peculiar ability of this organ to evacuate its contents of offending matters. Notwithstanding, we frequently find that even large curds will become an exciting cause in some susceptible children.

As before remarked, it is not always easy to distinguish between convulsions arising from opposite causes, notably those arising at the onset of eruptive fevers. These, however, are more apt to be preceded by prodromic symptoms, and accompanied by some of the characteristics of the fever. Convulsions, arising during the course of a disease, must always be looked upon as portending serious results, and, while they may be reflex, they are much more likely to indicate lesion of the brain. Notably is this the case in the second stage of hydrocephalus, where, we start, of course, with an inflammation, and where the effusion will be a serious complication.

INFANT FEEDING.

BY LORA C. JACKSON, M. D., PHILADELPHIA.

Hitherto children have been born almost anyhow; bred, fed, and treated almost anyhow; and feebleness, severe sickness, and the premature death of countless thousands, have been the results. In the ignorant age, the great mortality among infants was accounted for by the providence of God, against which it was in vain to strive, consequently, as a personal concern, the subject attracted but slight attention, and little was known of the real causes of this mortality. As a social interest, it was argued by many, that for the well being of nations, and to prevent a poor heredity, the feeble ones might even be helped to die.

Happily we have now reached an era where the "cry of the innocents" has obtained a hearing, and thoughtful men and women are beginning to feel, not only that the fate of the little ones is largely in the hands of their care-takers, but that education in this direction is really a far-sighted regard for the outcome of society at large. The need of such education may be measured by approaching the subject from the side of statistics.

Turning to some recent investigations concerning the mortality of infants, we are confronted with the appalling fact that ten per cent. of them die during the first month after birth, and twenty-five per cent. before the first year in life is completed. A few years ago, the statistics of France showed that a child just born has less chance of living one week than a man of ninety years; and less chance of living one year than an octogenarian (Routh).

It is well known that a large proportion of this mortality is due to diseases, caused by erroneous feeding and injurious hygienic surroundings. The same predisposing and exciting causes are found *in* hospitals and *out*, among the rich and the poor, every day and everywhere. The physician who is called upon to prescribe for the disorders of infancy has, therefore, to meet not only the difficulties of disease itself, but those, also, which arise from neglect of that careful attention to dietetic and hygienic rules which should be shown at this critical period of human life. Hence, we see that his work must be hygienic in the broader sense of the

word. Prescriptions for the actual disease must be supplemented by advice as to food, air, clothing, sleep, &c.

Leaving a large part of the theme we may inquire, What are the essential requirements as regards the feeding of infants?

All authorities agree that the breast milk of a healthy mother is the food best adapted for a child from its birth up to the time when the digestive organs are prepared for a more solid diet—a time that corresponds usually to the appearance of the first teeth. There is no diet equal to human milk in developing muscle, in making bone, blood and flesh, or in preparing the child to resist disease. When the mother is able to supply this nourishment there should be no question of a substitute. "All mothers," says Eustace Smith, "ought to try to nurse, partly for their own sake, and partly for the child's." Most physicians can call to mind many cases where delicate mothers, even, have nursed their infants with good results, not only to their offspring, but to themselves. When the mother is diseased, as with scrofula, to any extent; or when consumption, cancer, syphilis, or mania exists, it is always a question whether a child should be put to the breast.

"If we decide upon nursing by the mother, application to the breast should begin soon after birth—that is, within a few hours if the mother had sufficiently recovered from her fatigue—the milk obtained at this time being small in quantity but important, acting as a natural purgative and clearing out the bowels."

As soon as the milk is secreted the child should be applied to the breast at regular intervals of two hours or more, according to age—a rule that may be more easily adhered to if it be remembered that every cry does not mean hunger, and that often the child *may* be thirsty when it is restless and irritable between its nursing periods. In hot weather especially, should this relation of food and drink be remembered. Sometimes a little barley water may be given, but as a rule, pure water is best.

Many influences affect the quality of the mother's milk, and consequently the health of her child. If her secretions, as from the bowels, kidneys, skin, etc., are not healthy, the secretion of milk is not healthy, and so cannot afford proper nourishment to the child. Sorrow, anger, irritability of temper, or excitement of any kind, has a marked effect upon the character of the milk, and frequently

disorders the infant's bowels, producing vomiting and, sometimes, convulsions. The imperfect performance of the mother's digestive functions will account for many of the disorders of infancy which the physician is called upon to remove or alleviate.

All these influences must be carefully looked to in cases where the mother's milk does not seem to agree with the child. A homœopathic remedy selected with discrimination, with a proper régime of diet and hygiene, will usually overcome any ordinary difficulty. A lack of proper secretion may, ofttimes, be remedied by a greater supply of nourishment, a demand for which may be excited by cold bathing, followed by rubbing and kneading of the limbs. Galactorrhœa, a frequent source of trouble, may be traced to some uterine difficulty, or to immoderate nursing.

When the mother is only partially unable to supply the requisite nourishment for the child, she may be assisted by artificial foods. Meigs advises that all children who have attained the age of three or four months, be given, once a day, three or four ounces of artificial food, so as to prepare them for other diet than breast milk, in case the mother's supply should fail and premature weaning become necessary. When artificial food, in addition to the mother's own milk, is needed, cow's milk, prepared to meet the needs of the individual case, should be given through a feeding bottle. It ought to be given milk-warm. Great care should be taken that the milk be new and of good quality; and it ought to be kept in a clean, cool place, free from impure air. On the selection of a cow; the common red one is to be preferred to any fancy breed as it is less excitable, and not so liable to develop tubercular diathesis.

The great desideratum in preparing cow's milk for the bottle, is to make it resemble as much as possible a mother's own milk. Various measures are adopted to hinder the clotting of the casein, and to counteract the acid reaction of cow's milk. The methods which have been found the most generally useful are those proposed by Drs. Meigs and J. Lewis Smith.

If we decide upon the cessation of nursing by the mother, the question then arises, Shall a wet nurse be chosen as the substitute? This is an important question involving, in most cases, the interests of two mothers and their offspring; and yet, strange to say, only the claims of one mother and one child are usually considered in

answering it. If a wet nurse be chosen, the result is likely to be fatal to her own child, for when it is separated from its mother and deprived of its natural aliment and care, the chances are that its feeble life will soon go out.

But setting aside the claims of the wet nurse and her child, it is still doubtful whether the answer should be invariably in the affirmative. "It should be borne in mind," says Dr. Routh, "that the chances of life, precarious as they always are in a young infant, are rendered still more so by transferring a child to a wet nurse, other than its mother." Dr. Dunstan says: "I believe in having a wet nurse, when a proper one can be procured; but in the case of such a child, is of equal importance almost with the feeding it on the breast milk. I mean," says he, "that simply by breast feeding you cannot rear children. * * Employed wet nurses are frequently of the opinion that their function ends with the act of suckling the infant, and if so, the wet nurse is only a nuisance, a snare and a delusion." In the present stage of knowledge concerning artificial food for infants, wet nurses are, perhaps, necessary evils, but sometime hence, when we shall have learned to imitate more nearly the chemistry of nature, I believe we shall be able to make hand-feeding an efficient substitute for human milk."

The selection of a wet nurse is not only a difficult task for the physician, but casts upon him a great responsibility. The health of the wet nurse will, of course, be the truest guide, but several points are necessary in this examination. We must inquire particularly whether she be of a healthy family, or if she or any of her family have consumptive or other transmittable tendencies; if she has an abundant supply of *good* milk, remembering that a breast where there is increased adipose tissue may be mistaken for a full one. The best milk, and the richest, is usually found in the breasts of women of the brunette type. This is probably due to the fact that brunettes, as a class, are not only healthier, but of a more even temperament than women of the blonde type.

It is of great importance that the child of the wet nurse be of the same, or nearly the same, age as the one she is chosen to suckle. Finally, having made a choice, the same considerations which we have indicated for the mother should guide us in the management of her substitute.

We come now to the question of hand-feeding for infants wholly deprived of their natural nourishment, mother's milk. The great mortality of infants in foundling institutions, where children, like poor "Pip," are brought up by hand, has been attributed almost wholly to the want of breast milk, but many eminent authorities on infantile nutrition now agree that this mortality is not "due so much to hand-feeding as to the injudicious manner in which it is generally conducted." Dr. Smith says the disastrous results of ignorant attempts to supply a substitute for human milk have brought the whole practice of hand-feeding into disrepute; but if a food be judiciously selected, there is no reason why a child fed artificially, with judgment, should not thrive as well as one suckled naturally at the mother's breast.

In a large measure, the question of hand-feeding must be individualized, for the food that suits one infant may not agree with another. With regard to the best general substitute for human milk, Dr. Meigs says: "There can, I think, be no theory in regard to the diet of infants, except one founded upon a study of the composition of human milk, and an attempt to imitate it. As we have already said, cow's milk, properly prepared, is the best imitation known at present." Drs. Jacobi and J. Lewis Smith advise the admixture and use of one of the foods, to milk, from birth. If any of the foods are used, the kind and amount must be varied to suit individual cases.

The best way to nurse a child brought up by hand is by holding it in the arms and giving it the bottle in about the same position it assumes when being really nursed by its mother. The personal contact with the nurse or mother promotes warmth, while the position makes the effort of nursing less wearisome, both of which have their influence on digestion.

And now a word, in conclusion, with regard to the numerous prepared foods in the market. Condensed milk, the most convenient and easily prepared of all artificial foods, is not to be condemned without a hearing, the experience of many being that hand-fed children thrive on it better than on any other artificial diet. It is a question in my mind, however, whether children fed on condensed milk grow up as strong and vigorous as those fed on cow's milk.

Farinaceous substances, such as arrow-root, tapioca, etc., are very undesirable foods for young children. Infants do not secrete saliva until three months or more; therefore, they cannot digest farinaceous foods before that time, and even after that time those only must be selected which retain the gluten or nitrogenized portions.

Baked flour enters largely into the composition of most of the foods for children, by which process starch is converted into a soluble form. Nearly all of them have their adherents, and probably most of them have a certain value used with or without milk, as indicated; but they should be a last resort, to be used only after the different preparations of milk have been tried and found insufficient for the nourishment of the child.

DISCUSSION.

Dr. Clarence Bartlett opened the discussion by speaking of Dr. Bunting's reference to Barlow's often quoted remark concerning the etiological relation between hip-joint disease and phimosis. The speaker thought that the influence of phimosis as a factor in the production of reflex disorders was decidedly over-rated. He himself had never met with a case of either chorea, epilepsy or paralysis, in which genital irritation was the cause of the trouble or in which circumcision worked a cure; and of the former of these diseases, he had treated over one hundred cases. It has been said that circumcision lessens the tendency to masturbation. Only a few days before, he had conversed with a Jewish mother, both of whose children had been detected in the habit. So far as the cases of paralysis reported in our journals as resulting from this cause, very few could stand a very searching investigation. Dr. Bartlett did not wish to be understood as denying the influence of phimosis as a disease-producing factor, but merely as protesting against indiscriminate circumcision for the relief of widely varying conditions. Even in nocturnal enuresis, of which phimosis is a frequent cause, circumcision will not cure every case, by any means.

Dr. John E. James said that there were extremes on either side. He had cured several cases of nervous disease by removal of the

prepuce. He knew phimosis to be a common cause of reflex symptoms. He knew that this subject was being overdone, but he thought that care and judgment would prevent us from going to the other extreme.

Respecting the relation between croup and diphtheria, Dr. James expressed himself as believing that the two diseases were separate and distinct. He believed that statistics are fallacious because physicians fail, in preparing their reports, to give certain important information. Every case of croup should have its remote cause, if possible, assigned, especially as to whether or not it followed sore throat or some pharyngeal difficulty; whether it is a pure case of croup, or whether it follows or accompanies the constitutional symptoms of diphtheria. We ought to know diphtheria by its constitutional depression.

Dr. Pemberton Dudley said that it is more important for us now and for some years to come, to gather facts on this subject of the unity or duality of diphtheria and croup, than it is to form opinions on the truth or falsity of the doctrines involved. The facts at present at our disposal, do not warrant us in forming a definite opinion. There are cases occurring in the practice of all of us, that point strongly to the view that there is one cause operating to produce both diseases, or else that there are two or more causes which are generally found to co-exist. The latter seemed, to the speaker, to be the more rational view of the two. At the same time, we must not lose sight of the fact that croup was, when diphtheria was not. In 1859 or 1860, he did not think that the word diphtheria was mentioned by any professor lecturing at Jefferson College.

It is not an uncommon thing in spasmodic croup to have a recurrence of the disease on successive nights. Now, Dr. Dudley thought that, when under homœopathic treatment, this recurrence appeared over three nights, we should examine the patient pretty closely to see that there was no diphtheritic infection. He had treated a case in which the croup held on for four or five nights. He wondered that his remedies failed. Then the patient's little brother was taken with ordinary spasmodic croup. The mother then called his attention to the oldest child's knee, which had been wounded shortly before his illness. It was now covered with a

diphtheritic membrane. Then, the child received anti-diphtheritic remedies and improvement was at once manifested.

Dr. Wm. B. Trites said that the point he wished to make in his paper, was the danger of allowing cases of laryngeal diphtheria to mingle with other members of the family and with the public at large. As to the identity of croup and diphtheria, his mind was still open to conviction, although he thought that the bulk of the argument seems to be in favor of the identity of the two affections.

NEW BUSINESS.

This closed the report of the Bureaus. New business was next in order.

Dr. J. H. McClelland nominated Dr. Jno. W. Dowling, of New York, for honorary membership in the Society. Carried unanimously.

The Secretary presented the resignations of Drs. E. J. Lee and Wm. Jefferson Guernsey, from membership in the Society. Carried.

Dr. J. F. Cooper, reported a list of members indebted to the Society to the amount of fifteen dollars or more, and requested that the Society take some action on them.

On motion of Dr. Trites, the Treasurer was directed to communicate with the delinquents, learn the reason for the non-payment of their dues, and report to the Society at the next annual meeting.

Dr. Clarence Bartlett offered the following amendment to the by-laws:

"Should any occasion arise making it advisable or necessary to change the time and place of meeting agreed upon at the previous annual meeting, the same may be done by a vote of two-thirds of the officers of the Society, with the concurrence of the committee of arrangements.

REPORT OF THE COMMITTEE ON PRESIDENT'S ADDRESS.

Was next received and was as follows:

The committee to whom was referred the Address of the President of the Homœopathic Medical Society of Pennsylvania, begs leave to report, that they find it contains five distinct propositions, to wit:

1.—A law to have the teaching faculty separated from the licensing power.

2.—A law to protect physicians in their fees.

3.—A law to regulate the hours of work and rest of railroad employees, on account of danger to the public from overwork, or neglect on the part of the employees to take the proper rest.

4.—To endeavor to have an Insane Asylum under Homœopathic treatment, and asked that they be referred to the committee on legislation.

5.—To have the Bureau of Materia Medica continued for five years to the same members, to do continued work.

And an investigation into Swedenborg's scientific method.

In regard to the first recommendation, the committee reports adversely, the student's ability or qualifications being best known to the teacher, and that in their opinion the enforcement of a law in regard to the second cannot be enforced and is, therefore, impracticable.

In regard to the third and fourth propositions, we specially recommend the same to the careful consideration of the committee on legislation. In regard to the fifth proposition, we recommend that the committee on Materia Medica be continued for a period of five years according to our president's recommendation, with this addition, namely: that one member of this committee be retired each year, and a new member added.

In regard to the Swedenborg's scientific methods, most of us are entirely unacquainted with them and are unable to make any specific recommendations. Also that we recommend that the

thanks of the Society be extended to Dr. Cowley for his able and interesting address.

Respectfully submitted,

J. B. Wood, M. D.,
Pemberton Dudley, M. D.,
J. Arthur Bullard, M. D.

The report was accepted. The recommendation relating to the Bureau of Materia Medica, was so modified that the Bureau was directed to report, at the next meeting, a plan of action, in case the five year term of service was adopted.

REPORT OF THE COMMITTEE ON THE CORRESPONDING SECRETARY'S REPORT

Was as follows:

The undersigned, appointed by the Homœopathic Medical Society of Pennsylvania to report to your body upon what terms persons residing outside of the State can obtain copies of the Transactions of said Society, reports that they recommend that copies of the Transactions on hand from its organization until the present year (1886) can be obtained from the Secretary upon the payment of $8.00, when residing out of the State; or the sum of $6.00, to those residing within the State, until the copies on hand shall be exhausted.

They also recommend that all persons whose names appear upon the books of the Treasurer, or reported by him, as being in arrears for five years or more shall be stricken from the list of members of the Society; but may be re-instated within one year, thereafter, by the payment of all dues to the Society.

J. F. Cooper, M. D.,
J. B. Wood, M. D.

The Society then proceeded to the election of officers for the ensuing year and with the following result:

President.—A. R. Thomas, M.D., Philadelphia.
First Vice-President.—W. J. Martin, M.D., Pittsburgh.
Second Vice-President.—Edward Cranch, M.D., Erie.
Treasurer.—J. F. Cooper, M.D., Allegheny.
Recording Secretary.—Horace F. Ivins, M.D., Philadelphia.
Corresponding Secretary.—Clarence Bartlett, M.D., Philadelphia.
Necrologist.—W. R. Childs, M.D., Pittsburgh.
Censors.—Hugh Pitcairn, M.D., Harrisburgh; W. B. Trites, M.D., Philadelphia; H. W. Fulton, M.D., Pittsburgh.

Pittsburgh was chosen as the place for the next annual meeting, and the Allegheny County Society was made the local committee of arrangements.

The President then announced the bureaus and committees for the ensuing year as follows:

Committee on Legislation.—Hugh Pitcairn, M.D., Harrisburgh, *Chairman;* Pemberton Dudley, M.D., Philadelphia; J. H. McClelland, M.D., Pittsburgh; A. P. Bowie, M.D., Uniontown; and John K. Lee, M.D., and J. N. Mitchell, M.D., of Philadelphia.

Bureau of Materia Medica.—C. Mohr, M.D., Philadelphia, *Chairman;* J. C. Guernsey, M.D., C. S. Middleton, M.D., Augustus Korndœrfer, M.D., of Philadelphia; Z. T. Miller, M.D., Pittsburg; A. P. Bowie, M.D., Uniontown; S. Lilienthal, M.D., New York City; and E. Cranch, M.D., Erie.

Bureau of Clinical Medicine.—W. J. Martin, M.D., Pittsburgh, *Chairman;* Clarence Bartlett, M.D., Philadelphia; G. S. Boyd, M.D., Beaver Falls; David Cowley, M.D., Pittsburgh; S. W. S. Dinsmore, M.D., Sharpsburgh; R. K. Fleming, M.D., Pittsburgh; George M. Getze, M.D., Tarentum; D. R. Harris, M.D., New Castle; Maria N. Johnson, M.D., Philadelphia; J. M. Maurer, M.D., Washington; E. C. Parsons, M.D., Meadville; C. C. Rinehart, M.D., Pittsburgh; F. R. Schmucker, M.D., Reading; Thomas Nichol, M.D., Montreal, Canada.

Bureau of Surgery.—W. B. Van Lennep, M.D., Philadelphia, *Chairman;* Charles M. Thomas, M.D., Philadelphia; John E. James, M.D., Philadelphia; J. H. McClelland, M.D., Pittsburgh; W. R. Childs, M.D., Pittsburgh; J. J. Detwiller, M.D., Easton; L. H. Willard, M.D., Allegheny; Edward Reading, M.D., Hatboro;

H. J. Evans, M.D., Altoona; M. J. Buck, M.D., Altoona; J. William Giles, M.D., Philadelphia.

Bureau of Obstetrics.—J. Arthur Bullard, M.D., Wilkes-Barre, *Chairman;* J. N. Mitchell, M.D., Philadelphia; O. B. Gause, M.D., Philadelphia; Mary Branson, M.D., Philadelphia; C. F. Bingaman, M.D., Pittsburgh; H. H. Hofmann, M.D., Pittsburgh; O. T. Huebner, M.D., Lancaster.

Bureau of Gynæcology.—I. G. Smedley, M.D., Philadelphia, *Chairman;* H. J. Sartain, M.D., Philadelphia; B. F. Betts, M.D., Philadelphia; E. T. Schreiner, M.D., Philadelphia; Mary Branson, M.D., Philadelphia; C. H. Hofmann, M.D., Pittsburgh; Millie J. Chapman, M.D., Pittsburgh; W. A. Hassler, M.D., Allentown; R. P. Mercer, M.D., Chester.

Bureau of Pathology.—W. C. Goodno, M.D., Philadelphia, *Chairman;* W. K. Ingersoll, M.D., Philadelphia; J. C. Morgan, M.D., Philadelphia; W. D. King, M.D., Pittsburgh; I. B. Chantler, M.D., Sewickley; S. Starr, M.D., Chester; C. A. Wilson, M.D., Pittsburgh; E. L. Oatley, M.D., Philadelphia.

Bureau of Ophthalmology, Otology aud Laryngology.—W. H. Bigler, M.D., Philadelphia, *Chairman;* R. W. McClelland, M.D., Pittsburgh; Joseph E. Jones, M.D., West Chester; Horace F. Ivins, M.D., Philadelphia; W. H. Winslow, M.D., Pittsburgh; W. H. H. Neville, M.D., Philadelphia; H. C. Houghton, M.D., New York; W. A. Phillips, M.D., Cleveland, Ohio.

Bureau of Pædology.—Daniel Karsner, M.D., Philadelphia, *Chairman;* E. E. Davis, M.D., Philadelphia; W. B. Trites, M.D., Philadelphia; Lora C. Jackson, M.D., Philadelphia; S. F. Shannon, M.D., Sewickley; H. M. Bunting, M.D., Norristown; John K. Lee, M.D., Johnstown; M. M. Walker, M.D., Philadelphia; J. H. Closson, M.D., Philadelphia.

Bureau of Sanitary Science.—B. W. James, M.D., Philadelphia, *Chairman;* E. C. Parsons, M.D., Meadville; J. F. Cooper, M.D. C. D. Herron, M.D., Pittsburgh; J. B. Wood, M.D., West Chester; W. H. Malin, M.D., Philadelphia; Sarah J. Coe, M.D., Wilkes-Barre; T. M. Johnson, M.D., Pittston; P. Dudley, M.D., Philadelphia.

Delegates to American Institute of Homœopathy.—J. C. Burgher, M.D., Pittsburgh, *Chairman;* P. Dudley, M.D., Philadelphia;

L. H. Willard, M.D., Allegheny; A. Korndœrfer, M.D., Philadelphia.

Bureau of Organization, Registration and Statistics.—C. Bartlett, M.D., Philadelphia, *Chairman;* W. W. Van Baun, M.D., Philadelphia; J. S. Boyd, M.D., New Brighton; F. R. Schmucker, M.D., Reading; F. J. Slough, M.D., Allentown; M. M. Walker, M.D., Germantown.

After extending votes of thanks to the officers, the Society adjourned.

The following members and visitors were present during the sessions:

MEMBERS.—Drs. R. C. Allen, J. V. Allen, Clarence Bartlett, B. F. Betts, W. H. Bigler, Mary Branson, Chas. M. Brooks. Samuel Brown, H. M. Bunting, W. F. Berkenstock, Millie J. Chapman, Sarah J. Coe, J. F. Cooper, David Cowley, Isaac Crowther, E. E. Davis, Pemberton Dudley, Thos. S. Dunning, J. R. Earhart, E. Fornias, J. J. Garvin, E. M. Gramm, G. E. Gramm, T. J. Gramm, Silas Griffith, Wm. F. Griffith, F. O. Gross, J. C. Guernsey, B. B. Gumpert, J. W. Giles, Wm. A. Hassler, Horace F. Ivins, Lora C. Jackson, Bushrod W. James, John E. James, Horace E. James, Maria N. Johnson, Jos. E. Jones, Daniel Karsner, C. B. Knerr, Aug. Korndœrfer, W. H. Keim, John K. Lee, of Philadelphia, W. H. Malin, J. R. Mansfield, Anna M. Marshall, H. Noah Martin, Wm. J. Martin, C. S. Middleton, J. N. Mitchell. Chas. Mohr, John C. Morgan, W. P. Mullen, J. H. McClelland, E. H. L. McClure, W. H. H. Neville, C. W. Perkins, W. A. D. Pierce, Hugh Pitcairn, Trimble Pratt, J. W. Pratt, Wm. Peacock, E, Reading, J. H. Reading, H. J. Sartain, Emma T. Schreiner, W. P. Sharkey, E. S. Sharpless, F. J. Slough, I. G. Smedley, Samuel Starr, H. Knox Stewart, Horace Still, J. W. Strong, J. W. Thatcher, A. R. Thomas, Chas. M. Thomas, C. E. Toothaker, W. B. Trites, D. B. Umstead. C. Van Artsdalen, W. W. Van Baun, Josephine Van Deusen, Chandler Weaver, W. P. Weaver, L. H. Willard, Thos. C. Williams, M. S. Williamson, J. B. Wood, A. P. Bowie, M. J. Buck, J. A. Bullard, Henry Detwiler, W. C. Goodno, O. S. Haines, M. J. Holben, B. R. Marsden, R. P. Mercer, Z. T. Miller, L. W. Reading, Wm. Willets,

J. H. Young, Van R. Tindall, Gustave E. Bonnet, W. K. Ingersoll, Edwin Van Deusen, Jos. M. Gerhart, F. R. Schmucker, D. P. Maddux, J. H. Closson, E. L. Oatley, J. J. Griffith, W. A. Seibert, Jos. M. Reeves, Thos. H. Grimes, W. M. Zerns.

Honorary Members.—I. T. Talbot, John W. Dowling.

Visitors.—L. A. Snyder, T. S. Davis, R. Owen, E. F. Rink, H. B. Hall, T. C. Clark, J. C. Burns, Myra W. Normandie, F. W. Messerve, C. Albert Reger, George Godshall, Howard W. Long, E. W. Sackett, L. W. Thompson, E. A. Krusen, Edwin Van Deusen, James Kemble, S. Hastings Brown, Sarah T. Rogers, C. R. Norton, T. C. Imes, L. A. Smith, C. F. Stenger, F. Morton Long, A. C. Rembaugh, E. M. Howard, E. R. Snader, F. W. Kohler, R, U. B. Cornelius, E. C. Hyde, B. L. Baker, H. S. Campbell, William C. Roy, Isaac Cooper, of Trenton, N. J., T. D. Koons, George B. Peck, W. J. Truitt, S. Bryan Smith, S. H. Quint, M. F. Middleton, E. W. Mercer, George W. Smith, C. H. Conover, T. L. Adams, W. D. Rogers, E. Hasbrouck, Thomas F. Brock, H. P. Cheeseman, J. G. Streets, Anna C. Howland, E. E. Hancock, W. G. McCullough, and George T. Parke.

CONSTITUTION AND BY-LAWS.

CONSTITUTION.

ARTICLE I.—Name and Object.

This Association shall be known as the Homœopathic Medical Society of the State of Pennsylvania.

Its object is the advancement of medical science.

ALTICLE II.—Members.

This Society shall be composed of active, honorary and corresponding members, who shall be chosen in conformity with the By-Laws.

ARTICLE III.—Officers.

The officers of this Society shall be a President, two Vice-Presidents, a Recording Secretary, a Corresponding Secretary, a Treasurer, a Necrologist and a Board of Censors, consisting of three members, who shall be chosen at such time, in such manner and for such a period, and shall perform such duties as the By-Laws may direct.

ARTICLE IV.—Amendment.

The Constitution may be altered or amended by a vote of two-thirds of the members present at the annual meeting; provided, that notice of such intended alteration or amendment shall have been given to the Society, in writing, at the annual meeting next preceding.

BY-LAWS.

ARTICLE I.—Meetings.

Section 1. The annual meeting of this Society shall be held at ten A. M., at the time and place decided upon at the annual session next preceding.

Seven members shall constitute a quorum for the transaction of business.

Sec. 2. The elected officers of the Society shall have power to direct such other meetings to be held as they may judge advisable.

Sec. 3. Should any occasion arise making it advisable or necessary to change the time and place of meeting agreed upon at the previous annual meeting, the same may be done by a vote of two-thirds of the officers of the Society, with the concurrence of the committee of arrangements.

ARTICLE II.—Officers.

The officers shall be elected by ballot at each annual meeting of the Society, and shall enter upon their respective duties on the first day of January next succeeding their election.

ARTICLE III.—Duties of Officers.

Section 1. The President shall preside at the meetings of the Society, preserve order therein, put questions, announce decisions, and appoint committees not otherwise ordered. He shall deliver an address at the opening of the session.

Sec. 2. The Vice-Presidents, in the order of their election, shall perform the duties of the President, in his absence.

Sec. 3. The Recording Secretary shall keep a record of all the proceedings and resolutions, and of all discussions that may occur in the Society; authenticate, by his signature, all papers and acts of the Society, when the occasion requires it, and bring before the Society any business needing its action not otherwise presented.

Sec. 4. The Corresponding Secretary shall receive and preserve all letters addressed directly to the Society; open and maintain such correspondence as shall tend to advance its interests; give at

least two weeks' notice to the members of all meetings of the Society; keep a record of all members, with the date of admission of each; present all communications to the Society; notify all committees of their appointment and of the business referred to them, and notify all members of their election. He shall be *ex officio* chairman of the Bureau of Organization, Registration and Statistics.

Sec. 5. The Treasurer shall notify, annually, all members of their arrearages, collect all money belonging to the Society, and make all disbursements ordered by the Society. He shall furnish, at each annual meeting, a written report of his receipts and expenditures, and a statement of the condition of the finances.

Sec. 6. The Necrologist shall, upon the death of a member of the Society, prepare a suitable obituary and present it to the Society; he shall also forward a copy, properly engrossed, to the family of the deceased member, if so ordered by the Society.

The report of the Necrologist shall be presented in connection with the report and papers of the Bureau of Organization, Registration and Statistics.

Sec. 7. The Censors shall receive and examine the credentials of candidates for membership, and shall report to the Society, for election, such as may be found to be properly qualified.

Their report can be made in its regular order, or at the close of the report of any bureau.

ARTICLE IV.—Membership.

Section 1. *Active.*—A candidate for active membership shall present, to the Board of Censors, a written application, signed by himself, accompanied by a certificate from two members of the Society in good standing, that the applicant has received the degree of Doctor of Medicine from an incorporated medical college; that he subscribes to the doctrine of *Similia Similibus Curantur*, and that he sustains a good moral character. If found qualified, he may be elected a member. He shall not, however, be considered a member until he has paid an initiation fee of five dollars (which includes the first year's dues), and signed the Constitution, either in person or by proxy.

Any active member removing from the State, wishing to retain

his membership, shall notify the Society to that effect; otherwise his name shall be dropped from the roll.

Any active member who fails, either to attend the annual meeting or to send a paper once in five years, or to pay his dues, shall, upon vote of the Society, be dropped from membership.

Any member who shall be unable to comply with the requirements of this Society may be continued as an active member, without payment of dues, by vote of the Society.

SEC. 2. *Honorary.*—Any homœopathic physician, not a resident of Pennsylvania, who, from his superior attainments, may be judged worthy, may be elected an honorary member at any annual meeting, but no more than two shall be elected in one year.

Such honorary members shall have all the privileges of members, except the right to vote and to hold office.

SEC. 3. *Corresponding.*—Any homœopathic physician residing outside the United States may be elected a corresponding member at any annual meeting, but not more than two shall be elected in one year.

Such corresponding members shall have all the privileges of members except the right to vote and hold office.

ARTICLE V.—DUES.

Active members shall pay annually, in advance, the sum of three dollars toward defraying the expenses of the Society.

The published proceedings of the Society will be furnished only to those members who are not in arrears.

ARTICLE VI.—BUREAUS AND COMMITTEES.

SECTION 1. The following Bureaus shall be appointed as hereinafter provided:

One of Materia Medica and Provings.
One of Homœopathic Institutes and Clinical Medicine.
One of Surgery.
One of Obstetrics.
One of Gynæcology.
One of Pathology and Pathological Anatomy.
One of Ophthalmology, Otology, and Laryngology.
One of Pædology.

One of Sanitary Science.

One of Organization, Registration, and Statistics.

SEC. 2. Each bureau shall be composed of not less than five members.

SEC. 3. Each bureau shall present, in its annual report, a resumé of the discoveries and progress in its special department, together with the papers presented for discussion. The bureaus shall report in order of rotation each succeeding year.

SEC. 4. The Bureau of Organization, Registration, and Statistics shall receive all credentials of delegates to the Society; receive and preserve all reports from local or State societies, colleges, and other institutions; keep a record of the number of members admitted and withdrawn from the Society; solicit an exchange of publications with other State societies, and perform such other duties as may be directed by the Society. From these data, the annual report of the bureau shall be prepared.

SEC. 5. Immediately upon the close of the report of a bureau, the President shall appoint a chairman for the ensuing year; and the chairman so appointed shall, in conjunction with the President, select his associates, and the list of members of the bureau shall be announced before the close of the session.

SEC. 6. If any member of a bureau shall resign or decline to serve, the chairman of the bureau shall fill the vacancy by appointment, and notify the Corresponding Secretary of the fact.

SEC. 7. The following Standing Committees shall be appointed, as hereinafter provided for:

A Legislative Committee.

A Publishing Committee.

SEC. 8. Each of these committees shall consist of at least three members, to be appointed by the President.

SEC. 9. The Legislative Committee shall give special attention to all legislation involving the interests of the Society.

SEC. 10. The Publishing Committee shall publish and issue the Transactions to all who are entitled to receive them, within three months from the date of the meeting, unless otherwise directed by the Society at its annual meeting.

The Recording and Corresponding Secretaries and the Treas-

urer shall constitute this committee, but the number of members may be increased at the discretion of the Society.

ARTICLE VII.—Papers and Discussions.

Section 1. Each paper presented to the Society shall be through its appropriate bureau. All papers to be presented by any bureau shall be in the hands of the chairman thereof at the opening of the session; and it shall be the duty of each writer to prepare an abstract, which will accompany the paper when handed in, and the chairman shall decide whether the abstract only, or the entire paper be presented to the meeting for its consideration and discussion. All papers shall be subject to the approval and revision of the Committee of Publication. No report or paper will be received by the Society in an incomplete or unfinished condition; and no paper shall be published as part of the Transactions which has been previously published.

Sec. 2. All communications read before the Society shall become its property; but no paper shall be published as part of the Transactions of the Society without its sanction.

Sec. 3. All discussion shall be strictly confined to the subject of the paper or report, and each speaker shall be limited to a speech of ten minutes, and to one of five minutes if he speaks a second time, and no excess of time shall be allowed except by consent of the Society. The reader of the paper shall be allowed ten minutes at the close of the discussion.

Sec. 4. Each county or local society shall be invited to prepare and discuss, during the year, a paper upon some medical subject, and present it to the Society at its annual meeting, through its appropriate bureau.

ARTICLE VIII.—Amendments.

These By-Laws may be altered or amended by a vote of two-thirds of the members present at any annual meeting.

ORDER OF BUSINESS.

1. Calling meeting to order.
2. Address by the President.
3. Roll-call and correction of list of members.
4. Appointment of Committee on President's Address.
5. Report of Treasurer.
6. Appointment of Auditing Committee.
7. Report of Corresponding Secretary.
8. Reports of committees.
9. Report of Censors and election of members.
10. Reports of bureaus.
11. Unfinished business.
12. New business.
13. Election of officers.
14. Announcement of bureaus and committees.
15. Adjournment.

LIST OF MEMBERS.

1885—Allen, John V., M.D., Frankford, Philadelphia.
1870—Allen, J. W., M.D., Altoona.
1883—Allen, Richard C., M.D., 4519 Frankford Av., Phila.
1885—Arthur, Charles, M.D., Richfield, Kansas.
1883—Baker, Alfred E., M.D., Wynden Farm,West Chester.
1885—Baker, C. H., M.D., 34 N. 40th Street, Philadelphia.
1881—Bartlett, Clarence, M.D., 1506 Girard Av., Philadelphia.
1885—Berkenstock, W. F., M.D., 1207 Wallace Street, Phila.
1875—Betts, B. F., M.D., 1609 Girard Avenue, Philadelphia.
1886—Bier, P. A., M.D., Pittsburgh.
1872—Bigler, W. H., M.D., 118 N. 12th Street, Philadelphia.
1873—Bingaman, C. F., M.D., 922 Penn Avenue, Pittsburgh.
1886—Bonnet, Gustav E., M.D., 636 N. 11th Street, Philada.
1872—Bowie, A. P., M.D., Uniontown.
1884—Boyd, G. S., M.D., Beaver Falls.
1880—Boyd, J. S., M.D., New Brighton.
1882—Boyer, Francis W., M.D., Pottsville.
1875—Bradford, L. J., M.D., Sylvania.
1883—Branson, Mary, M.D., 1719 Arch Street, Philadelphia.
1872—Brickley, Obadiah C., M.D., York.
1881—Brooks, Charles M., M.D., 1613 N. 10th Street, Phila.
1883—Brown, Samuel, M.D., 651 N. 10th Street, Philadelphia.
1879—Buck, M. J., M.D., Altoona.
1885—Buchman, Frank, M.D., 1410 S. 5th Street, Philadelphia.
1886—Bulick, T. M., M.D., Altoona.
1877—Bullard, J. A., M.D., Wilkes-Barre.
1881—Bunting, H. M., M.D., Norristown.
1866—Burgher, J. C., M.D., 960 Penn Auenue, Pittsburgh.
1868—Carmany, C. J., M.D., Harrisburgh.
1873—Chantler, I. B., M.D., Sewickley.

1875—Chapman, Millie J., M.D., 916 Penn Avenue, Pittsburgh.
1868—Charlton, S. T., M.D., Harrisburgh.
1866—Childs, W. R., M.D., 934 Penn Avenue, Pittsburgh.
1885—Christine, G. Maxwell, M.D., 2042 N. 12th Street, Phila.
1886—Closson, J. H., M.D., 914 North Broad Street.
1883—Coe, Sarah J., M.D., Wilkes-Barre.
1873—Cook, I. Elmer, M.D., Harrisburg.
1866—Cooper, J. F., M.D., 42 N. Diamond St., Allegheny City.
1866—Cowley, David, M.D., 6442 Penn Avenue, Pittsburg.
1882—Cranch, Edward, M.D., Erie.
1875—Crawford, J. S., M.D., Greensburg.
1883—Crowther, Isaac, M.D., Chester.
1883—Davis, E. Everett, M.D., 4224 Brown Streets, Phila.
1882—Dean, E. W., M.D., Braddock.
1885—Deardorff, J. H., M.D., Mechanicsburg.
1866—Detwiller, Henry, M.D., Easton.
1866—Detwiller, John J., M.D., Easton.
1879—Detwiller, J. W., M.D., Bethlehem.
1886—Dietz, W. G., M.D., Hazleton.
1878—Dinsmore, S. W. S., M.D., Sharpsburg.
1880—Doolittle, E. D., M.D., Easton.
1867—Dudley, Pemberton, M.D., 15th and Master Streets, Phila.
1878—Duff, P. S., M.D., Great Belt.
1882—Du Four, W. M., M.D., Williamsport.
1875—Dunn, James L., M.D., Titusville.
1881—Dunning, T. S., M.D., 1328 North 15th Street, Phila.
1870—Earhart, J. R., M.D., 1904 Arch Street, Philadelphia.
1873—Edmundson, W. F., M.D., 375 Fifth Avenue, Pittsburg.
1882—Evans, H. J., M.D., Altoona.
1880—Ferson, J. L., M.D., 137 Wylie Avenue, Pittsburgh.
1884—Fleming, R. K., M.D., Pittsburgh.
1883—Fornias, Eduardo, M.D., 327 Pine Street, Philadelphia.
1873—Fulton, H. W., M.D., 5949 Penn Avenue, Pittsburgh.
1867—Garvin, John J., M.D., 1546 N. 11th Street, Phila.
1866—Gause, Owen B., M.D., 1519 Arch Street, Philadelphia.
1883—Gause, Percy O. B., M.D., 1519 Arch Street, Philadelphia.
1886—Gerhart, Joseph M., M.D., 603 N. 12th Street, Philadelphia.
1870—Gessler, C. W., M.D., 1332 S. 5th Street, Philadelphia.

1879—Getze, G. M., M.D., Tarentum.
1885—Giles, J. William, M.D., 1206 Race Street, Phila.
1875—Goodno, W. C., M.D., 4003 Chestnut Street, Philadelphia.
1875—Graham, D. M., M.D., Chicago, Ill.
1883—Gramm, E. M., M.D., 934 N. 6th Street, Philadelphia.
1867—Gramm, G. E., M.D., Gwynedd, Montgomery County.
1883—Gramm, T. J., M.D., 1636 Vienna Street, Philadelphia.
1886—Griffith, J. J., M.D., Manayunk, Philadelphia.
1881—Griffith, Silas, M.D., 1431 Girard Avenue, Philadelphia.
1877—Griffith, W. M., M.D., 2035 Ridge Avenue, Philadelphia.
1886—Grimes, Thomas H., Sewickley.
1883—Gross, F. O., M.D., 1409 N. 4th Street, Philadelphia.
1874—Guernsey, J. C., M.D., 1923 Chestnut Street, Philadelphia.
1867—Gumpert, B. Barton, M.D., 840 Franklin Street, Philadelphia.
1886—Gundlach, F. C., Pittsburgh.
1885—Haines, O. S., M.D., 137 N. 15th Street, Philadelphia.
1879—Hall, William D., M.D., Altoona.
1883—Hancock, Joseph, M.D., 1639 Columbia Avenue, Phila.
1884—Harris, D. R., M.D., New Castle.
1883—Hassler, W. A., M.D., Allentown.
1881—Hawley, Annie M., M.D., Pughtown.
1883—Helfrich, J. H., M.D., Allentown.
1873—Herron, C. D., M.D., 17 Butler Street, Pittsburgh.
1882—Hofmann, C. H., M.D., 808 Penn Avenue, Pittsburgh.
1866—Hofmann, H. H., M.D., 808 Penn Avenue, Pittsburgh.
1883—Holben, M. J., M.D., Slatington.
1883—Horner, J. Richey, M.D., 107 Arch Street, Allegheny.
1871—Huebener, O. T., M.D., Lancaster.
1880—Humes, J. R., M.D., Hollidaysburg.
1886—Ingersoll, W. K., 4008 Chestnut Street, Philadelphia.
1882—Ivins, Horace F., M.D., 1319 Arch Street, Philadelphia.
1883—Jackson, Lora C., M.D., 1526 Arch Street, Philadelphia.
1866—James, Bushrod W., M.D., 18th and Green Streets, Phila.
1885—James, Horace E., M.D., 1229 S. 8th Street, Philadelphia.
1867—James, John E., M.D., 1521 Arch Street, Philadelphia
1870—James, Walter M., M.D., 1123 Spruce Street, Philadelphia.
1877—Johnson, Maria N., M.D., 1732 Green Street, Philadelphia.
1881—Johnson, Theo. M., M.D., Pittston.

1869—Jones, Joseph E., M.D., West Chester.
1881—Karsner, Daniel, M.D., 4830 Main Street, Germautown.
1885—Keim, Wm. H., M.D., 2015 Ridge Avenue, Philadelphia.
1875—Kern, W. H., M.D., McKeesport.
1884—King, W. D., M.D., 328 Fifth Avenue, Pittsburgh.
1877—Knerr, C. B., M.D., 112 N. 12th Street, Phlladelphia.
1873—Koenig, M. J., M.D., Jersey Shore.
1872—Korndœrfer, Aug., M.D., 648 N. 12th Street, Philadelphia.
1884—Lee, Chas. H., M.D., New Castle.
1866—Lee, John K., M.D., 3800 Chestnut Street, Philadelphia.
1879—Lee, John K., M.D., Johnstown.
1873—Lefever, Isaac, M.D., Harrisburgh.
1867—Lippe, Ad., M.D., 1204 Walnut Street, Philadelphia.
1866—Liscomb, P. D., M.D., Beaver Falls.
1868—Macfarlan, Malcolm, M.D., 1805 Chestnut Street, Phila.
1886—Maddux, D. P., M.D., Chester.
1883—Maguire, W. T., M. D., Darby.
1866—Malin, John, M.D.. 70 W. Chelten Avenue, Germantown.
1877—Malin, Wm. H., M.D., Chestnut Hill, Philadelphia.
1881—Mansfield, J. R., M.D., 4852 Main Street, Germantown.
1886—Marks, W. F., M.D., Reading.
1885—Marsden, Biddle R., M.D., 1513 N. 2d Street, Phila.
1883—Marshall, Anna M., M.D., 1608 Mt. Vernon Street, Phila.
1866—Martin, H. N., M.D., 1218 Walnut Street, Philadelphia.
1877—Martin, W. J., M.D., 1712 Carson St., S. S,, Pittsburgh.
1878—Maurer, J. M., M.D., Washington.
1881—May, Newton, M.D., Holmesburg.
1871—Mercer, Robert P., M.D., Chester.
1871—Middleton, Caleb S., M.D., 646 N. 10th Street, Phila.
1877—Miller, Z. T., M.D., 1726 Carson St., S. S., Pittsburgh.
1883—Mitchell, J. N., M.D., 1222 Walnut Street, Philadelphia.
1875—Mohr, Charles, M.D., 555 N. 16th Street, Philadelphia.
1867—Morgan, John C., M.D., 110 S. 17th Street, Philadelphia.
1881—Mullen, S. A., M.D., West Chester.
1883—Mullin, W. P., M.D., 5007 Green Street, Germantown.
1879—McClelland, J. B., M.D., 411 Penn Avenue, Pittsburgh.
1867—McClelland, J. H., M.D., 411 Penn Avenue, Pittsburgh.
1884—McClelland, R. W., M.D., 411 Penn Avenue, Pittsburgh.

1883—McClure, Eliza H. Lang, M.D., 811 N. 20th Street, Phila.
1866—Neville, W. H. H., M.D., 19th and Wallace Sts., Phila.
1886—Oatley, E. L., 1519 Arch Street, Philadelphia.
1884—Parker, G. W., M.D., 1404 S. 6th Street, Philadelphia.
1883—Parker, T. Ellwood, M.D., Claremont, N. H.
1870—Parsons, Anson, M.D., Springboro.
1881—Parsons, E. C., M.D., Meadville.
1880—Peach, Wm., M.D., 76 Monterey Street, Allegheny City.
1885—Peacock, Wm., M.D., 2217 N. 6th Street, Phila.
1881—Perkins, C. W., M.D., Chester.
1883—Pettingill, Eliza F., M.D., 300 N. 10th Street, Philadelphia.
1870—Pierce, W. A. D., M. D., 2004 Mt. Vernon Street, Phila.
1880—Pitcairn, Hugh, M.D., Harrisburgh.
1886—Posey, L. P., M.D., 1232 Arch Street, Philadelphia.
1883—Powell, W. C., Jr., M.D., Bryn Mawr.
1881—Pratt, J. W., M.D., Coatesville.
1871—Pratt, Trimble, M.D., Media.
1866—Preston, Mahlon, M.D., Norristown.
1875—Ramage, R. H., M.D., Mansfield Valley.
1872—Rankin, J. S., M.D., 59 Grant Street, Pittsburgh.
1866—Raue, Charles G., M.D., 121 N. 10th Street, Philadelphia.
1867—Reading, E., M.D., Hatboro.
1883—Reading, J. H., M.D., 1811 Green St., Phila.
1886—Reading, L. W., M.D., Hatboro.
1886—Reeves, Jos. M., M.D., 1609 Mt. Vernon St., Phila.
1878—Rinehart, C. C., M.D., Marion Station, Pittsburgh.
1871—Rittenhouse, S. R., M.D., Reading.
1880—Robson, J. W., M.D., Pittsburgh.
1873—Roseberry, C. I., M.D., Easton.
1883—Ross, S. C., M.D., Scranton.
1883—Rousseau, L. G., M.D., 628 Penn Avenue, Pittsburgh.
1872—Rutter, J. C., M.D., Bloomsburg.
1872—Sartain, Harriet J., M.D., 210 Franklin Street, Phila.
1874—Schmucker, F. R., M.D., Reading.
1883—Schreiner, Emma T., M.D., 20th St. and Lehigh Av., Phila.
1880—Scott, S. C., M.D., Pittsburgh.
1886—Seibert, W. A., M.D., Easton.
1868—Seip, C. P., M.D., 636 Penn Avenue, Pittsburgh.

1875—Shannon, O. R., M.D., 207 Lacock Street, Allegheny City.
1879—Shannon, S. F., M.D., Sewickley.
1883—Sharkey, W. P., M.D., 1938 Girard Avenue, Philadelphia.
1881—Sharpless, E. S., M.D., 901 N. 8th Street, Philadelphia.
1885—Shellenberger, C. N., M.D., 1831 Wallace Street, Phila.
1883—Shemp, P. D., M.D., 1117 Green Street, Philadelphia.
1883—Skeels, J. S., M.D., Albion.
1883—Slough, F. J., M.D., Allentown.
1883—Slough, W. C. J., M.D., Emaus.
1880—Smedley, I. G., M.D., 1319 Arch Street, Philadelphia.
1870—Spencer, J. H., M.D., 1306 N. 7th Street, Philadelphia.
1881—Stambach, H. L., M.D., Santa Barbara. California.
1883—Starr, Samuel, M.D., Chester.
1883—Stewart, H. Knox, M.D., 810 N. Broad Street, Phila.
1883—Still, Horace, M.D., Norristown.
1885—Strong, J. Wilmer, M.D., 2049 N. 13th Street, Phila.
1881—Swartz, J. R., M.D., Harrisburg.
1881—Thatcher, J. W., M.D., 35th and Hamilton Streets, Phila.
1871—Thomas, A. R., M.D., 1733 Chestnut Street, Philadelphia.
1877—Thomas, Charles Monroe, M.D., 1313 Arch Street, Phila.
1886—Tindall, Van R., M.D., 240 Federal Street, Phila.
1886—Thompson, J. H., M.D., Pittsburgh.
1881—Tomlinson, W. H., M.D., 5210 Main Street, Germantown.
1881—Toothaker, C. E., M.D., 1717 Francis Street, Philadelphia.
1882—Trites, W. B., M.D., 4500 Baker Street, Manayunk, Phila.
1881—Umstead, D. B., M.D., Tacony, 23d Ward, Philadelphia.
1877—Van Artsdalen, C., M.D., Ashbourne.
1883—Van Baun, W. W., M.D., 419 Pine Street, Phila.
1886—Van Deusen, Edwin, 2004 Tioga St., Phila.
1883—Van Deusen, Josephine, M.D., 21st and Tioga Sts., Phila.
1881—Van Lennep, W. B., M.D., 410 S. Broad Street, Phila.
1867—Walker, Mahlon M., M.D., 12 W. Walnut Lane, Germantown, Philadelphia.
1881—Wareheim, Edward A., M.D., Glen Rock.
1870—Waters, George H., M.D., 474 N. 6th Street, Philadelphia.
1880—Way, J. H., M.D., West Chester.
1881—Weaver, Chandler, M.D., Fox Chase, 23d Ward, Phila.
1883—Weaver, W. P., M.D., Bristol.

1870—White, N., M.D., New Castle.
1866—Willard, L. H., M.D., Western Avenue, Allegheny City.
1881—Williams, H. E., M.D., Coatesville.
1866—Williams, Thomas C., M.D., 567 N. 5th St., Philadelphia.
1873—Williamson, M. S., M.D., 1311 Arch Street, Philadelphia.
1870—Willits, William, M.D., Williamsport.
1886—Wilson, C. A., M.D., Allegheny City.
1877—Winslow, W. H., M.D., 956 Penn Avenue, Pittsburgh.
1883—Wood, H. C., M.D., West Chester.
1866—Wood, James B., M.D., West Chester.
1883—Yearsley, Wm., M.D., 1532 N. 13th Street, Philadelphia.
1880—Yoder, D., M.D., Catasauqua.
1874—Young, J. H., M.D., 1630 Green Street, Philadelphia.
1880—Zerns, W. M., M.D., Philadelphia.

HONORARY MEMBERS.

1883—Allen, H. C., M.D., Ann Arbor, Mich.
1868—Dake, Jabez P., M.D., Nashville, Tenn.
1866—Doran, Charles R., M.D., Jacksonville, Fla.
1886—Dowling, Jno. W., M.D., New York.
1868—Helmuth, William Tod, M.D., New York City.
1885—Houghton, Henry C., M.D., New York City.
1876—Jones, S. A., M.D., Ann Arbor, Mich.
1876—Lilienthal, S., M.D., New York City.
1868—Paine, H. M., M.D., Albany, N. Y.
1883—Phillips, W. A., M.D., Cleveland, O.
1868—Rockwith, F. A., M.D., East Saginaw, Mich.
1868—Talbot, I. T., M.D., Boston, Mass.

CORRESPONDING MEMBERS.

1873—Alvarez, Paz, M.D., Madrid, Spain.
1873—Chauvet, Fernand, M.D., Tours, France.
1873—Eidherr, Francis, M.D., Vienna, Austria.
1883—Hughes, Richard, M.D., Brighton, England.
1873—Nichol, Thomas, M.D., Montreal, Canada.
1873—Pope, Alfred C., M.D., London, England.

NECROLOGICAL LIST.

1866—Ashton, A. H., M.D., died February 18th, 1883.
1866—Barnaby, John E., M.D., died January 5th, 1869.
1867—Barrett, Charles B., M.D., died June 5th, 1871.
1882—Bernard, H., M.D., died
1866—Blakely, W. James, M.D., died January 14th, 1877.
1870—Bratt, Benj. R., M.D., died January 31st, 1872.
1866—Brooks, Silas S., M.D., died July 2d, 1871.
1883—Burr, Richard, M.D., died March 30th, 1885.
1873—Caruthers, R. E., M.D., died January 3d, 1885.
1866—Cooke, Wm. H., M.D., died March 21st, 1879.
1866—Cote, M., M.D., died May 29th, 1878.
1871—Dreibelbis, David L., M.D., died March 24th, 1872.
1870—Farrington, E. A., M.D.. died December 17th, 1886.
1866—Friese, Michael, M.D., died February 4th, 1880.
1866—Frost, J. H. P., M.D., died January 21st, 1875.
1866—Gardiner, Richard, M.D., died March 22d, 1877.
1877—Grumbein, William, M.D., died———
1866—Guernsey, H. N., M.D., died June 27th, 1885.
1870—Guernsey, Wm. F., M.D., died February 16th, 1877.
1866—Herron, James A., M.D., died November 15th, 1868.
1884—Hosfeld, George, M.D., died November 9th, 1884.
1873—Houard, J. G., M.D., died April 24th, 1878.
1866—James, David, M.D., died June 6th, 1873.
1866—Jeanes, Jacob, M.D., died December 18th, 1877.
1866—Koch, Augustus W., M.D., died May 4th, 1886.
1871—Lovejoy, E., M.D. (honorary), died August 15th, 1872.
1868—Malin, George W., M.D., died January 18th, 1883.
1866—Marsden, J. H., M.D., died August 27th, 1883.
1866—McClatchey, R. J., M.D., died January 15th, 1883.
1870—Moore, Thomas, M.D., died March 25th, 1882.
1869—Ostrander, W. M., M.D., died August 23d, 1881.

1868—Payne, Wm. E., M.D. (honorary), died March 9th, 1877.
1878—Pereira, Ignacio, M.D. (correspond'g), died April 18th, '81.
1868—Pfouts, J. S., M.D., died———
1866—Preston, Coates, M.D., died August 9th, 1881.
1868—Pulte, J. H., M.D. (honorary), died February 24th, 1884.
1882—Pursel, J. E., M.D., died March 15th, 1885.
1866—Reading, Jno. R., M.D., died February 14th, 1886.
1870—Reinhold, H. E., M.D., died March 6th, 1879.
1866—Roberts, R. Ross, M.D., died April 4th, 1875.
1866—Rousseau, L. M., M.D., died September 25th, 1882.
1872—Scott, James L., M.D., died August 15th, 1876.
1872—Speth, W. F., M.D., died May 11th, 1881.
———Stauffer, D. R., M.D., died March 16th, 1874.
1867—Stevens, C. A., M.D., died January 17th, 1881.
1870—Taudte, F., M.D., died March 27th, 1878.
1866—Williamson Walter, M.D., died December 19th, 1870.
1866—Williamson, Walter M., M.D., died May 5th, 1874.

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ERRATA.

Page 74 line 4 from the bottom, for "power" read "poorer."
Page 74 line 10 from the top, for "before" read "refuse."
Page 75 line 5 from the top, for "house" read "houses."
Page 75 line 16 from the top, for "factions" read "factors."
Page 77 line 13 from the bottom, for "this" read "their."
Page 86 line 10 from the bottom, insert "case" after "this."
Page 88 line 7 from the top, for "there" read "then."
Page 345 for "Alticle II," read "Article II."
Page 360 line 7 from the top for "Gebruary" read "February."